Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Davidson December 22 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 6. Sex **XX**M 2□ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Director Apr. 2, Pennsylvania 1923 179-14-4277 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20851 United States Funeral 605 Denham Road filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2□No World I Yes, Give Year or Dates: War ∏ 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced War II White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) iges 1 and 2 should be filed within nt of Heelth and Mental Hygiene.

If Item 27 is marked other than 'or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Electrical Mechanical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be f h and Mental F Catherine Clifford 2 John F. Davidson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24816 Woodfield School Road, Gaithersburg, MD 20882 Francis J. Davidson/Son 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition December 20c. Location - City or Town, State Pages 1 Cemetery 27, 2006 Silver Spring, MD.

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue

M00803 Rockville, Maryland 20850-2805 1 Buriai 2 □ Cremation 3 □ Removal from State permit. Page Depertment o Important: If any Injury or 4 Donation 5 Dother (Specify) 21. Signature of Buneral Service Libensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) minutes Preumothorax **Physician** lension /Medical Due to (or as a consequence of): Examiner Emphysem years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached for □Yes 2□No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed?. 1□ Yes 2**X**No ospital or Attending Physician: The hours after death.
uneral Director: After this certificate by filled in by the funeral director, par 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes X No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062553 2006 December 22, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Gaithersburg Patsu MCNEI 31. Date filed (Month, Day, Year) 32. egistrar's Signature State DEC 2 6 2006 Registrar

DHMH 17 Rev 1/2001

			For Stete Registrar	State o	f Marylan		rtment of H	lealth and N Death		rgiene 2 0 0	6 41002
	Physici		Decedent's Name (First, Middle	operson					2. Date of De Month	aath	3. Time of Death
1	/Medio Examir		4a. Facility Name (If not institution Franklin Sq.	n, give street and nu.	Spital	1	Kose	r Location of Death		4c. County of E	timore
	Funeral Director		5. Social Security Number 219-50-7024 Usual Residence of Decedent	6. Sex 12 M 2 □ F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July	DQ1 rth ay, Year) 12,1948	Birthplace (State or Foreign Country) Maryland
	with the Maryland a or 28a-f ehow	tor	10a. State 10b. County	ltimore	10c. City	Mide	ation dle Riv	er			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the	Director	10e. Street and Number 1041 Ches	ster Ro	24		10f. Zip Code	0		10g. Citizen of Wha	t Country?
CNT	irs after death will, or items 238	by Funeral	11. Marital Status 1 Never Married 2 Marital Signature 4 Divorced	12. Was Dec Armed Fo ied 117 Yes	edent Ever in U. orces? 2 No ve	lf	2122 Vas Decedent of H Yes, specify Cuba □ Yes 2□ No	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	Black, V	American Indian, Vhite, etc. White
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Mary	d 2 should th and Mer ?? ie marke traumatic		19a. Informant's Name/Relations Vera Gallie			1				oer, City or Town, Sta	
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Balti	permit. Pages Depertment of Important: If I any injury or once.		21. Signature of Funeral Service	Licensee	mell	//	Name and Address	120		ce Ave.B	alto. MD
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	com, live til ns that conty a cause on e	caused the dear			ig, such as cardiac			Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box	ne death cer the attendir thed for use	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live t	tcome of pregna birth 2 □ Fetal nant at time of de own	death 3 🗌	Ectopic pregnancy Other (specify)	'		23d. Date of Month	delivery Day Year
ords, P.	w requires that the been signed by should be detact	ed by Ph	Part II. Other significant condition	ons contributing to d	eath but not resu	ulting in the un	derlying cause giv	en in Part I.			te to the cause of death? Probably 4 □Unknown
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fVit	Physiciar this certif al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient	3□ DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho		one) idence 6 □Other (Specify)
ision o	ttending Ph death. ctor: After thi r the funeral	Certification;	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation not be	of Injury th, Day Year)	28b. Time of Injury	M 28c. Injun Worl 1 □	yat k? Yes 2 □No		how injury occurred	r Rural Route Number,
D.	Hospital or A 24 hours efter Funeral Directely filled in by		4 Homicide determ	build	ing, etc. (Specify	")			City or Tò	wn, State)	
	To the Hospital or Attendi within 24 hours eiter death. To the Funeral Director: A completely filled in by the fi	Medical	(Check only 2 Medical one)	Exeminer: On the band man	e best of my know easis of examinat oner stated.	wledge, death ion and/or inv	estigation, in my o	pinion, death occur	and due to the red at the time,	cause(s) and manne date and place, and	due to the cause(s)
	5 1 1 5 0		29b. Signature and title of certifie	Ner				061662		29d. Date signed (A	12006
	2		st. Jonathan	who completed cause	9000	Frank	un Sq.	Drive 1	Ba Itim	ove, ma	1 21237
, n 1	Sta Registi		31. Date filed (Month, Day, Year) DE.C 2 6	67	legistrar's Signa	K Kon	all!			,	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#26, per VERB. G862, 127,26706 WS

State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Curtis Ennis 6:35 Riember 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Bulhmore Co Hospital DINGI NA 01 8 Date of Birth (Month, Day, Year) 2-21-55 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1**∑** M 2□ F Hours 396-68-6465 Yrs 51 MI Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore NA 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5506 Magnolia Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Truck Driver Fisher Catering Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ennis Wallace Aire Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13216 Robinson St, Detroit, MI 48227 Jerome Ennis Brother Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-22-06 Greenmount Cem. Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East l adys 1101 E. North Ave., Baltimore, Md. 21202 con 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Disseminated ntravascular day Due to (or as a consequence of): 0515 Due to (of as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred

or Attending Physicien: The law requires thet the death certificate be executed

Physician

/Medical

Examiner

10a. State

Md.

Funeral

Director

rthen "naturel", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at

filed within 72 hours after

permit. Pages 1 and 2 should be filed will Department of Heelth and Mental Hygien. Important: If Item 27 is marked other the any injury or other traumatic event, Imagine.

Itimore, Maryland 21215-0036

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Funeral Director

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Division of Vital Records, P.O. Box 68760,

To the Hospitel DHMH 17 Rev 1/2001

Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No ed by the detached 9 Unknown certificate has been signed rector, pege 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Completed : After this certifical funeral director. 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 ☑ No ှ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 27. Manner of Death 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 December 18 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julia Tu, MD Sinui Hospital of Julia 31. Date filed (Month, Day, Year) 🐲. Registrar's Signature State Registrar DEC 26 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #1, PI, 23a line b, PII, 25, per WF tiff Cate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** FRAIZER 1324 06 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BATTIMORCE OF MARYLAND MED. CTR UNIVERSITY If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Sept. 21, 9. Birthplace (State or Foreign 1948 **Funeral** 1∭ M 2□ F Country) Ohio 58 Sept. Director 268-46-1523 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nt: If item 27 is marked other than "naturai", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1√ Yes 2 No Directo Dhio Hamilton Cincinnati 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45223 1600 Thompson Heights Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Network Temp Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Burnus J. Fraizer Natalie E. Hanner ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Fraizer (Wife) 1600 Thompson Heights Ave., Cincinnati, OH 45223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) D/W Crematory 12/13/06 Columbus, OH 22. Name and Address of Facility
C.D. White & Son Funeral Home
1217 Mt. Vernon Ave., Columbus, OH 43203 21. Signature of Funeral Service Ligensee ennis Unecu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HEMORRA disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner DUCH CETTER ON AS ROYED BY MEDICAL EXAMINE Sequentially list conditions, if any, boung to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cocaine use; Hypertensive atherosclerotic cardiovascular disease icate has been sli 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Yes 1 MInpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural (Month, Day n 24 hours after death, ne Funeral Director: A oletely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1440 8 12/4/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2

State Registrar Softw

31. Date filed (Month, Day, Year)

PERKINS

2006

STREET

110 S. PACA

32 Registrar's Signature

6Th Floor BAHO. MD.

06-09778 Alannah Franklin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 41005

		Registrar		Cer	tificate c	t Death			F	Reg No.		
Physicia	_	1. Decedent's Name (First, Midd	ile,Last)						2. Date of De			3. Time of Death
edical Exami		Alannah			Er	anklin			Month December	Day ar 23 2	Year	0055 hrs
		4a. Facility Name (if not institution	on give street and num	her)		4b. City, Town	or Location				County of Dear	th
		709 Portland Street		,		Baltimore						
			T T-						<u> </u>			
Funeral		Social Security Number	6. Sex 7.	. Age (In yrs. Ia	ist birthday)	If Under 1		ier 24Hrs.	8. Date of B	irth (MM/	DD/YYYY) 9. Bi Fore	irthplace (State or
Director		149-76-2736	1 M 2XF	28	3 Yr		Days Hour	s Min.	Sept.	10.	1978\e€	PunDersey
		Usual Residence of Decedent										
any		10a State 10b County		10c. City,	Town or Loca	tion		-				10d Inside City Limits
* *	1											1 X Yes 2 No
and f sho	5	Maryland		Balt	imore							1 X 163 2 140
fary at c	S	10e. Street and Number				10f. Zip Cod	е			10g. Citi:	en of What Col	untry?
he A	Director	709 Portland St	reet			21230)			TT	S.A.	
,ith		11. Marital Status	12. Was Deced	dent Ever in U.S	S 13 W	as Decedent of		igin? (Sper	cify Yes or N			rican Indian, Black,
ath v	Funeral	1 X Never Married 2 N	Married Armed Ford	ces?		Yes, specify Cu				·	White, etc.	, , , , , , , , , , , , , , , , , , , ,
or de	교	3 Widowed 4 Di	1 Yes	2 X No		\					0 / 11	
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sd v bell	١Ō	17. Father's Name (First, Middle	e, Last)				18.Mothe	r's Name (I	First, Middle,	Maiden	Surname)	
tal F	Be	Vincent Frankl	lin				The	resa	Frank	lin		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	.0	19a. Informant's Name/Relation			19b. Marlir	ig Address (S	treet and Nu	mber or Ru	ral Route Nu	ımber, Ci	ty or Town, Stat	e, Zip Code)
Sho and and matis	_	Vincent Frankl	lin (Fathe	r)							NY 12518	
ore, MD 21215-0036 Set and 2 should be filed within 72 hours after death with the Maryland of Hatth and Mandal Hygiene in 172 hours after 23 and 18 marked other than "natural", or items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	LIII (Taciic			sition (Name of			Date		ocation - City o	
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The I firem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other S	Specify:	St.	Thoma	s Ceme	ery_	12/	28/06	Co	ornwall.	, NY
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is		21 Sign yure of Funeral Service	The second secon		22.	Name and Add	ess of Facili	ty				
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/Medical		failure. List only one cause									311, 31 113211	Between Onset and
xaminer		Immediate Cause (Final disease	e a <u>Burro</u> pi	on and pr	romethaz	ine into	cication	1				Death
J.		or condition resulting in death)	Due to (or as a c	onsequence of):							
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S 8 5	ä	events resulting in death) Last	Due to (or as a c	onsequence of):							
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Affk funes	Ë	1 Natural		Day,Year)	28b. Time of	injury 200.		z.	8d. Describe	a now inju	iry occurred	
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Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	2	and manner sta									
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		Club2				0.	C.M.E.			Dec	ember 23, 2	2006
		30 Name and address of perso	on who completed cause	of death (Item	23a)	I						
d	l i	·	ssistant Medical Ex			Street, Balt	more MF	21201				
10		Alla Kubiu Wib. As	iolotalit Micalcal L.	A a i i i i i i i i i i i i i i i i i i	I I I CIIII	Otroot, Dan						
	tate			istrar's Signatu								

Physician /Medical Examiner

Funeral Director

r 28a-f show notified at show ms 23a or 7 death r than "natural", or Items the Medical Examiner mu nit. Pages 1 and 2 should be fifed within 72 hours after artment of Health and Mental Hygiene.
ortant: If Item 27 Is marked other than "natural", or Itel Injury or other traumatic event, the Medical Examines Department o Important: If any injury or

3altimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed the burial-tran Division or Vital Records, P.O. Box 68760, physician use as t for been signed by the should be detached page 2 s Hospital or Attending Physician: funeral director, this After n 24 hours after death.

Funeral Director; A letely filled in by the fu

within 24 hor To the Fune completely fi 10

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Constance Elaine Farrell 10:34 PM 2006 20, December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Montgomery Hospice Casey House If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months Min. 1 □ M 2 🕅 F 034-12-0307 81 August 22, 1925 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits Director Rockville 1 X Yes 2 ☐ No Maryland Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 1004 Aster Boulevard United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Volunteer Program Coordinator Montgomery County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Leo Hebert P Cleruida Eva Lillian Beauchamp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1846 Wood Parke Lane, Commerce Township, MI 48382 Jill E. Broo / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, Virginia 26, 2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Peritoneal Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Day 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus, Type 2 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 🛛 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4□ Nursing Home 5□ Residence 6 ☑Other (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12-21-2006 m Milliams Do ninia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Cynthia M. Williams D.O. 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year)
DEC 2 6 2006 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 24, 2006 Mary December 11:11 am /Medical Elaine Gi bson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16 A Glenwood Road Baltimore Essex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □XF Director 212-66-5659 53 27,1953 Washington D.C. Sept. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 ☐Yes 2 XNo Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n Funeral 16 A Glenwood Road Pages 1 and 2 should be filed within 72 hours after deathnent of Health and Mental Hygiene. 21221 S. A.

14. Race - American Indian, ral", or Items 2 Examiner mu . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ð 3 ☐ Widowed 4 ☑ Divorced 'natural", White Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7 Is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Specialist Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Bangert, Sr. Patricia Miller ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 t of Health a Department of Health Important: If item 27 any injury or other tr once. Timothy Gibson (Son) 203 Westown Road 1st Floor Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 12/26 2006 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part1. Enter the disease, or complication and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to r as a consequence of) Minut C /Medical Examiner y ears Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of The law requires that the death certificate be executed burial-transi 9 Kars Due to (or as a consequence of): and Box 68760. physician s the burial Physician/Medical year hypertensio attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day 5 ☐ Other (specify) ed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has b irector, page 2 sl 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performe 1∐ Yes 2X No Hospital or Attending Physician: funeral director Be 25. Was case referred to medical 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 1 XYes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending nours after death.

Ineral Director; Af

v filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0003239 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gar. triedna 1245 E9STERN 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/200

State Registrar

DEC 2.6

06-09639 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Gemmill, Sr. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day December 17, 2006 2353 hrs Medical Examiner Robert George Gemmill, Sr. 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Bayview Medical Center N/AIf Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9 Birthplace (State or **Funeral** Months Days Hours Min. Foreign Director Country) 1 X M 2 F Yrs 219-52-3718 05. 1951 Maryland Dec. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 10b County Any Yes 2 X No or 28a-f show other than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at once. Sparrows Point Maryland Baltimore Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country United States 6986 River Drive Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces White etc 1 Never Married 2 Married Yes 3 Widowed f Yes, Give Year Divorced 1 Yes 2 X No specify: Specify White 1. Pages 1 and 2 should be filed within 72 hours after timent of Health and Mental Hygiens are ratait. If item 27 is marked other than "natural", or other tranmatic event, the Medical Examiner. è 16a. Decedent's Usual Dccupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) should be filed within 72 h and Mental Hygiene Elementary/Secondary (0-12) Baltimore, MD 21215-0036 12 years Garage Owner Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Hyram Gemmill Mary Opal Goodnough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert G. Gemmill, Jr. (Son) Grange Road Dundalk, Maryland 21222 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Important; Donation 5 12/22/2006 Other Specify Middle River, Hill Mem. Gdns. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk. Maryland 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease ⊂xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit The law requires that the death certificate be executed cal UNPENDED AMENDED attending physician or use as the burial Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Day Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' Yes 2 1 🗸 Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25 Was case referred to medical uneral director, æ examiner? Other₄ After this Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ို 1 Yes No 28a. Date of Injury (Month, Day Year) Dec 17, 2006 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification Driver auto fixed object collision 2322 hrs Natural 1 Yes 2 ✔ No Pending Funeral Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 4115 North Point Road, , MD determined (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 and manner stated. 29b, Signature and title 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 18, 2006 30. Name and address of person who completed cause of death (Item 23a) 0 Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar		State of	Marylar		artmen ertificat			and M	lental Hyg	ienę _{g. No.}	006	41009
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			BALT I MORE - WASH 5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday		1 Year	I E If Under	24 Hrs.	8. Date of Birth		9. Birt	hplace (State or Foreign
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Deperment of Heelth and Menial Hygiens. Deperment of Heelth and Menial Hygiens insturel; for iteme 23a or 28e-f ehov Important: if item 27 ie marked other then "naturel; or iteme 23a or 28e-f ehov any injury or other traumatic event, ite Medical Examinar must be notified at any injury or other traumatic event, ite Medical Examinar must be notified at any injury.	ဥ	unk 19a. Informant's Name/Rela	tionship (T)	/pe, Print)		19b. Ma	ling Address		unk and Numbi	er or Rura	al Route Number	r, City or	Town, State,	Zip Code)
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Division of Vital	or Al after of Direction by	Certification:	4 Homicide	etermined	209. Flaut	e of Injury - At ing, etc. (Spec	ify)	Street, ractor	y, onice			City or Tow	in, State))	19.2.1100.0.100.1
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of c	ertifier				29	c. Licen:	se number			29d. Date	e signed (Mon	th, Day, Year)
	/		ASA5			m			04	397	7	1)con	When	19 2006
	h		36 Name and address of po	rson who	completed cau	se of death (tte	om 23a) (Typ	e, Print)	n				2.~	1	
	J		Lyokh Exis	ng.	BUI Ite	Britzel	Dane	, Cilo	1 5	45	e.	mo.	2100	01.	
642	St Regist	ate	31. Date filed (Month, Day,		1	Registrar's Sign	nature	malls 8							
	negisi	Tal	DEC 2	6 20	UD ATE	Market at	J. All	The same							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 12/19/2006 Mildred L. Herchenhahn 6:30 P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Renaissance Garden Catonsville Baltimore 8. Date of Birth (Month, Day, Year)
Dec. 25, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 1 1 F 97 1908 Maryland Director 216-09-0060 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Maryland Catonsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? be filed within 72 hours after death with intal Hygiene. 707 Maiden Choice Lane, RGT 227 21228 USA Funeral 14. Race · American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Office Manager Small Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental H John Herchenhahn Emma Plate 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 5912 Prince George Street, Baltimore, Maryland 21207 27 John W. Metcalfe / POA 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 iment of H 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 12/23/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licens 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that initiated events resulting in death) Last and certificate be exec Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☐ No autopsy performed 1□ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. To the Hospital

> State Registrar

h

29b. Signature and title of certifier

30. Name and address of person who completed co

of death (Item 23a) (Type, Print)

29c. License number

<u> 18908 a</u>

711 Maiden Choice Lane, Catonsville, Maryland 21228

29d. Date signed (Month, Day, Year)

December 20 2006

and manner stated.

32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

DEC 26

2006

LAND,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month <u>5:35</u> am^M 23. 2006 December Audrey Ruth Holcomb 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Essex 1705 Langley Road If Under 1 Year Months Days Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Hours 1 □ M 2 X F Maryland 75 5/18/1931 215–30–0047 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Race - American Indian, Black, White, etc. 21221 1705 Langley Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo Specify. Specify: Year or Dates: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hamilton Muriel Frank Benton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1705 Langley Road Essex, Maryland 21221 Samuel Russell Holcomb (Husband) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 12/27/2006 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Middle River, Maryland Holly Hill Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part1. Enter the disease, or carplication that caused the disease, or heart failure. List only on cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Metas ancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No au ccv 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed? 1□ Yes 2☒No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760. signed by the at d be detached for within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 1 ary or other traumatic event, the Medical Examiner must be not prother traumatic event, the Medical Examiner must be not or the traumatic event.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event, once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examine

by Physician/Medical

Be Completed

Certification: To

Medical

State Registrar

the Maryland

6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital

of person who completed cause of death (Item 23a) (Type, Print) Carbell Klul

11614

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4920 32. Registrar's Signature

WW

Vital Records, Division or

HENDERLITE

MARGARET

21

DECEMBER

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. TARIQ MAHMOOD

DEC 26

2300 DULANEY VALLEY RD.

32. egistrar's Signature

29c. License number

43725

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

12/22/06

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:00a^M 20, 2006 4c. County of Death John Thomas Harvey, Jr. December /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 409 Fourth Avenue Lansdowne Baltimore Jan • 26, 1928 7. Age (In yrs. last birthday) 78 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□ F Months Days Hours Min. Mary land 216-20-5368 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ₹ No MDBaltimore Lansdowne Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 409 Fourth Avenue 21227 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married ※ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ White 3 Widowed 4 Divorced Year or Dates: Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Fire Officer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Thomas Harvey, Sr. ဂ Henrietta Greene 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Fourth Avenue, Lansdowne, MD 21227 Louise R. Harvey - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 10 Other (Specify) 12-23-2006 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Strvice Licentee Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Prumona weak **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): of the lu **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and retely filled in by the funeral director, page 2 should be detached for use as the burlat-fransit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obstructive 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2□ No 1 ☐ Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atte within 24 hours after de:

To the Funeral Directo completely filled in by th 3 Suicide 4 Homicide 1 C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10 State 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 1001

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

12/21/2006

AVE, BALTO, MD 21229

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Holden Adele /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Cente NA If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□ M 20 F 219-01-9498 Director 131 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director MD timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3601 eenwar Funeral Was Deceden Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygione. Important: if item 27 is marked other than "natural" or item any injury or other traumout. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor/ Writer Local Community 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henr Jane haura 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Street Milford, Mr. Elroy Holden 100 Dru (Brether) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) remajor 12/28/06 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Russ Joseph L. Rus L. The. takes RUENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ancreasic **Physician** disease or condition resulting in death) ancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed 24a Was an autopsy performed? Yes 2 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Anther (Specify) NOS PLC 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 □ No

Division or Vital Records. P.O. Box 68760. Attending Physician: death. 6 To the Hospital or within 24 hours aft To the Funeral Di

3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
29a. Certifier (Check only one) Certifying Physical Certifying Physical Examination	lician: To the best of my knowledge, death oc ner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place tigation, in my opinion, death occu	, and due to the caus	se(s) and manner as stated. e and place, and due to the cause(s)
29b. Signature and title of certifier	~	29c. License number 58303		1. Date signed (Month, Day, Year) CEMUU 22 2006
30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, Prin	"Charks St BA	anne.	MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Day

Year

4c. County of Death

06

Baltimore

USA

Black, White, etc.

Diekerson

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Month

Delaware

Black

Specify:

2:21 AM

10d. Inside City Limits

Approximate Interval Between Onset and Death

montas

1 Yes 2 □ No

10 State

Medical

Registrar

MARLIES, MO Gosale Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** Hunter 1:15a Thomas 12 19 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore NA Longgreen N.H. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ₹M 2 ☐ F 244-01-9689 Ga. Director 86 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2 No Baltimore Director NA Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21202 908 Valley Street Completed by Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Butcher Various 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Allen Hunter Mamie P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ms. Edna Harris Daughter 1022 Valley Street, Baltimore, Md. 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-23-06 Druidridge Cem. Baltimore, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East, Baltimore, Md. 21202 1101 E. North Ave. lady wan Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on e pah line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a conse A nce of) **Examiner** Sequentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quence of) Physician/Medical Examiner The law requires that the death certificate be executed ng physician and as the burial-tran Division or Vital Records, P.O. Box 68760. attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Day in the past 12 months 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 1 1 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to edical examiner? 26. Place of Peath (Check only one) Be Other: 4 Unursing Home 1 Inpatient 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes ဥ 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year, Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determine 4 Homicide 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

2

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Bear di Aparle

25

Registrar's Signature

death (Item 23a) (Type, Print)

ORIGINAL

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			1 - For State Registrar	State of M	aryland		artment of H rtificate of L			giene 0 0	6	410	17
	Physici /Medio		Decedent's Name (First, Midd Nova	H. Hudson					2. Date of Dea Decembe		ΰΰ6	3. Time o	P M
7	Examir		4a. Facility Name (If not institution Pickersgil	-			4b. City, Town, or Towson	Location of Death		4c. County of Balti			
	Funeral Director		5. Social Security Number 212-01-4645	6. Sex 7. Ag	e (In yrs. la 92	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV . 2	3, 1914	9. Birthpla Count Wes	ace (State	or Foreign g ini a
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10	d. Inside C	City Limits
	he Mar 28e-f s	ector		timore	Tow	son	T						2 X No
	h with t	al Dir	10e. Street and Number 615 Chestnut	Ave.			10f. Zip Code 21204	1	1	I0g. Citizen of W		ry? SA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel', or items 23e or 28e-f show any injury or other treumatic event, the Medical Evantrian must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 🗶 Widowed 4 ☐ Divorced	If Vac Give		· '	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race Black Specify:	, White, e	itc.	
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Maryland	should be filk and Mental Hy marked oth umatic event	To Be (17. Father's Name (First, Middle, Fred Hetric					18. Mother's Nam Grace	Mitche)		
	and 2 sho saith and n 27 is m		19a. Informant's Name/Relation. Mrs. Terry Pro				g Address (Street a					Code)	
nore	Pages 1 nent of He int: If iten		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation		cer	netery, crer	sition (Name of natory or other place Episcopal			20c. Location - C	•		
Baltimore,	permit. P Departme Importen any injury		*4 □ Donation 5 □ Other (\$ 21. Signature of Fugeeral Service		Siler	22	. Nangur Addres		eral Hop			, ma	•
	2 0 ≥ € 0		23a. Part1. Inter the disease, o	r complications that caused	the death.	Do not ent	TUSU YC					Approximat	te
	Physician /Medical Examiner		snock, or near failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	1-	Stance of):	a 065t	retu	ne leur	y dise		Interval Ber Onset and	
1/2	uted d ansit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	ence of):							
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	w requires Ihat been signed b should be deta	by	Part II. Other significant conditions	- 1	ut not result		nderlying cause give	on in Part I.	23e. Did tot	pacco use contrib es 2 No 3		e cause of c	
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Vita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:		2/0.1	Othe		th (Check only on	-/	/		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year DECEMBER 50 PM 14 2006 Samuel Johnson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAINT BALTIMORE AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days **M** M 2 □ F 74 732-50-1420 07 16 32 NC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 1509 North Hilton Street U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Beth Steel Corp. na Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Loubertha Johnson Thomas Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Johnson-Wife 1509 North Hilton Street, Balto, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Defiation 5 □ Other (Specify) King Memorial Park 12/20/06 Randallstown, Md 21. Signature of Funeral Service Ucensee March F/H West 4300 Wabash Ave, Baltimore, Md Mum PSIX 21215 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA 3 DAYS Due to (or as a consequence of): BRONCHIOLITIS 1 month UBLITERANS ORGANIZING PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation (Month, Day Year) 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2006

DECEMBER 14

BALTIMORE

Physician /Medical Examiner

Examiner

Physician/Medical

Completed

Be

P

Medical Certification:

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier

KWAME NTIM

KWAME NTIM

Physician

/Medical

Examiner

Funeral

Director

28a-f show notified at

23a or Examiner must be

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the state of

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permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If item 27 is marked other any Injury or other traumer.

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within 72 hours after

Maryland 21215-0036

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Director

Funeral

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Completed

physician and s the burial-transit as attending p been signed by the should be detached

cate has page 2 s certificate director. After this funeral

Records, Vital Division or or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the f Hospital

> State Registrar

6 ☐ Could not be

determined

, STAGNES HOSPITAL 32 Registrar's Signature

SAD 44.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

,900 CATONS AVENUE GOBOLL

MEDICAL DOTTER

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P20805

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 23 recember 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City

HUnder 1 Year | HUnder 24 Hrs. | 8. Date of Birth
Tolor | Davs | Hours | Min. | Time | 0, 193 General N/A Hospita Maryland 7. Age (In yrs. last birthday)
73 Yrs. 3 South Carolina 5. Social Security Number 6. Sex **Funeral** 215-28-278 Usual Residence of Decedent 1 M 2 KF Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "neturel", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 XYes 2 □ No Funeral Director more 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? X 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian, 11. Marital Status Black White etc. 1 end 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired), 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Barmai ith and Mental Hygis 27 is marked other r treumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be bean lar srown 19a. Informant's Name/Relationship (The, Print) (SISTER) 19b. Mailing Address | Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s
Department of Heelth ar
Important: If item 27 is
eny injury or other treu 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date X Burial 2 ☐ Cremation 3 Removal from State 12007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
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ZZZZ W. North Ave Funeral Home. Home 23a. Part Enter the disease, or complications that can be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart trailine. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Anoxic encephalopathy Samentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed neumonia Due to (or as a consequence of): 68760. Physician/Medical ettending p Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. page 2 should be detached 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? 2 1 No 1 Yes Hospitat or Attending Physician: ours after death.

nerel Director: After this certifica filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ဥ 1 ☐ Yes 2 Ø No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

State Registrar DHMH 17 Rev 1/2001

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To the I

completely

Medical

29a. Certifier

(Check only one)

laryam 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

DEC 2

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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0/8

32 Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The Destroying Provided in the Destroy Renowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

lon Steven Klaas	1	- For State	St	ate of M	aryland		artment (<i>rtificate</i> (Menta	al Hy	giene	Reg. No	. 00	3 (3)	- 1 1	0.0
Physician		Registrar 1. Decedent's Name	∍ (First, Midd	le,Last)					.		- 2	2. Date of D	eath	2	10	3. Time of Death	U C
Medical Examine		Jon	L	Stephe	en	Kla	assen					Month Decemb	Day D er 18 ,	, 2006 Year		1724 hrs	
-		4a Facility Name (if		n, give street	and number)				y, Town, or L	ocation of	Death		ľ	4c. County o	f Death		
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Funeral		5. Social Security N		6. Sex	7. Ag	e (In yrs. I	ast birthday)		nder 1 Year nths Days	If Under Hours	24Hrs. Min.	1			9. 8irt Foreig	nplace (State or	
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	ပ္ခု	17. Father's Name (Calvin R							- 1					en Surname)			
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Baltimore, permit Pages I ar Department of Hee Important: If ite injury or other tr	ŀ	4 Donation 5 21. Signature of Fur	Other S, neral Service	Licensee					and Address	of Facility	Hal	ll Fur	nera	1 Home		VII	
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Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the fluspital or Attending Physician: The law requires that the death certificate be executed. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit.	Medical	one) 2 🗸	Medical Exa	miner:On the	e basis of exa	mination a	and/or investi	gation, in	my opinion,	death occ	urred at	the time, d	ate an d p	place, and du	ue to the	cause(s)	
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12.35	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year)	9. Birt	hplace (State or Foreign untry)
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Maryland	should being Menta	To	Hugh Josep	_			-		nia Mar			
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: If item 27 is marked other then "naturel; or items 23a or 28a-f show important: If item 27 is marked other then "naturel; or items 23a or 28a-f show any highry or other traumatic event. If a Medical Examination must be notified at once.		4 Nonation 5 Other			_	2. Name and Addre	_	ylor's	Fune	ral	Home
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100	/Medical		resulting in death)	Due to	o (or as a conseq	uence of):						
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	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Cert (Check only one)	ifying Physicien: To ical Examiner: On the and m	the best of my kn basis of examin anner stated.	owl edge, de ation and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) an date and pla	d manner a ace, and di	as stated. ue to the cause(s)
	othe vithin is outle	Mec	29b. Signature and title of ce		A1		29c. Licen	ise number		29d. Date s	igned (Mo	nth, Day, Year)
	,,		Dun	1000	UL	-V~) N	5095	-4	1	21	25/06
	11		30 Name and address of pe	non who completed c	ause of death (Ite	m 23a) (Typ	Print)	WAL	DORF	, M	Q:	20603
		tate	31. Date filed (Month, Day,	(ear) 3 3 6 2006 A	Pegistrar's Sign	nakure	ale					
	Regis	trar	Marie Co	0 5000	N. C.	1						

			For	State of Marylar	nd / Depart	ment of H	lealth and	-	•	1.1021
			1 - State Registrar		Certif	ficate of	Death		g. No.	71024
	Physici /Medic		1. Decedent's Name (First, Middle, La Charles A.					2. Date of Death Month December	Day 10 200.	
	Examir		4a. Facility Name (If not institution, give Franklin Sq.Uov	. 11 1/1./	48	b. City, Town, o	r Location of Dea	th	4c. County of Dea	in Mare
	Funeral		5. Social Security Number 6. S		M	f Under 1 Year Ionths Days	If Under 24 Hrs Hours Min	. (Month, Day,	Year) 9. Birt	thplace (State or Foreign
	Director		Usual Residence of Decedent					Apriize	5,1916 MA	
	a Maryla a-f ehov	ctor	MD Balti		ty, Town or Locati Midd	lle Riv	ver			10d. Inside City Limits 1 ☐ Yes 🏖 No
)	3a or 28	Funeral Director	10e. Street and Number 724 Seneca Pa	ırk Road		10f. Zip Code 2122()	10	g. Citizen of What Co USA	ountry?
•	ns 2	era	11. Marital Status	12. Was Decedent Ever in U	I.S. 13. Was	Decedent of H	lispanic Origin? (Specify Yes or No- to Rican, etc.)	14. Race - Ame	erican Indian,
980	be filed within 72 hours after death with the Maryland tal Hygiene. ad other then "neturel" or Items 23s or 28s-f show event, Its Medical Examinar must be rodified at	Ď	1 ☐ Never Married 2 ☐ Married 3 € Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	as, specify Cuba Yes 2⊠ No		rto Rican, etc.)	Black, Whit Specify: Wh	
2-0	72 ho	eted	15. Decedent's E (Specify only highest gr		16a. Decedent	t's Usual Occup d of work done	pation during most of wo d)	orking 1	6b. Kind of Business	Industry
21215-0036	2 should be fited within and Mental Hygiene. ie marked other then 's aumatic event, It a Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired s Rep.			Beach G	oods
ā	Hygi other	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, M	faiden Sumame)	
/ar	S should be fited and Mental Hygi ie marked other aumatic event, I	To B	Charles H. Li	psey			Nel	lie Bail	ey	
Maryland	s 1 and 2 should f Health and Men Item 27 ie marke other traumatic		19a. Informant's Name/Relationship (Are a second				City or Town, State,	
	of Health Item 27		Charles A. Li						ltimore	
nor			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	Place of Disposition cemetery, cremato ak Lawn	ory or other place	erv 12		Oc. Location - City or Baltimo	
Baltimore,	permit. Page Depertment o Important: If eny injury or once.		21. Signature Funeral Service Lice			ame and Addre			Ave.Bal	
	8979		rolly len	Janely 4			Funer	al Home	of Essex	21221
	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each line.	S Red	e mode of dylr	ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consec	quence of):					
T	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consec	quence of):					
, 09 <i>L</i>	ite be executed sysicien and ne burial-transit	cai Exa	resulting in death) Last	Due to (or as a consec	quence of):					
89	tificate ig phy as the			0.						
P.O. Box	The law requires that the death certificat tie has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous	aldeath 3 ⊟Ed	topic pregnancy ther (specify)	/		23d. Date of dei Month	ivery Day Year
	quires that the signed by and be detacted	室	Part II. Other significant conditions	contributing to death but not res	sulting in the unde	rlying cause giv	ren in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	raicien: The law requir s certificate has been si director, page 2 should i	Completed						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
tal		0	25. Was case referred to medical				26 Place of De	1 ☐ Yes 2 ath (Check only one		2 No
of Vital	Physicien: this certific ral director,	0 8	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA Oth	oc		nce 6 Other (Spe	cifv)
0	ng Phya ter this neral di	T:T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe how		
Sio	ttendir death. ctor: Af / the fu	atic	2 Accident investigation	n			Yes 2 □No			
Division	To the Hospital or Attending I within 24 hours effect death. To the Fundral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined		ome, farm, street, fy)	factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ural Route Number,
	Hospi 24 hour Funer etely fill	Medica	29a. Certifier f Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death oc ation and/or invest	curred at the tir tigation, in my o	me, date and plac pinion, death occ	e, and due to the car urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)
	14		· Cade			Kes	00000		ecember	20, 2006
	A		30. Name and address of person who		n 23a) (Type, Prir	nt)	and the same of	6.500 A	la la Maria	11 91000
	1		31. Date filed (Month, Day, Year)	Aegistrar's Signa	ature :	HYIN	your.	DIVE &	ZUSTHILOTU)	TIM 2193/
	Sta Registi		DFC 2.6.20	59	& Prosel	80	•		/	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 50 AM OVI a December 20 2006 /Medical 4b:)City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 5 OW 1 m 6 V 4 a anda If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day Year) 20 If Under 1 Year 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 20 F Yrs 213-18-1207 MD Director 86 Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 28a-f ehov traumatic event. Its Medical Exandrer hast be notified at Baltimore 1 X Yes 2 ☐ No NA MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code itema 23a or 21215 3916 Calloway Ave #405 death \ Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: if then 27 ie marked other then any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Black X□ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aide Hospital 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie Peterson Robert Matthews 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
#6 Oak Ridge Drive, Jacksonville, AR 72076 19a. Informant's Name/Relationship (Type, Print) Elise M. Redmond-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Randallstown, King Memorial Park 12/23/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 La 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10 disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner ed by the attending physicien and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificete 2□ No 1 ☐ Yes 2 🗹 No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending death. 1 Yes 2 No 2 ☐ Accident investigation Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2006 20

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 5 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 5-6:05 P M Moaner 21 06 Howard /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Deaf **Examiner** Avenue Haddon Baltimore 5310 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Yrs. 219-10-8158 Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28s-4 show or other traumatic event, it a Modical Examiner must be muilitied at 1 Pres 2 No Himore Director NA MID 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue Hadden USA 5310 21207 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21 No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service etter Carrier Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental Richard Moaney annie Hayman 19a. Informant's Name/Relationship (Type, fint) Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health as Important: If item 27 is eny injury or other trau QNC. Haddon Avenue Doris Moane 5310 Baltimore NID 21207 20a. Meth of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other place) 1 Furial 2 Cremation 3 Removal from State Moodlawn 12/27/06 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sunature / Funeral Service Licensee 22. Name and Address of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and stransit Due to (or as a consequence of) Records, P.O. Box 68760, by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how intury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and mpleted cause of death (Item 23a) (Type, Print) 10 Center St. 32. Pegistrar's Signature. 31. Date filed (Month, Day, Year) DEC 2 6 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Regis Amend #6 Per FH C862 12/28/06 Opertificate of Death Reg. No. 2 U U 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 40 FM DELEMBER 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner NA HOPKIN HOSPITAL BALTIMERE 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5-9-1952 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 54 214-56-8168 Md. Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 No Baltimore Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21218 USA 2862 Harford Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ∰ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 2 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. It and Mental Hygiene. 7 is marked other than "n: Elementary/Secondary (0-12) College (1-4or 5+) Residential Counselor Aunt C.C. Harbor House 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ George Montague Geraldine Newman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traum once. Wendy Hunter Financee 2862 Harford Rd., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cem. 12-22-06 Lansdowne, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East ladr 1101 E. North Ave., Baltimore, Md. 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Myczardia day disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 s been significant band b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2: autopsy perform funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No Hospital or Attendl 24 hours after death. Funeral Director: A etely filled in by the fu death. 2 Accident Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MEDICAL DOCTOR -000

State Registrar

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HOSPITAL, 600 NORTH WOLFE STREET MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

LANORY,

31. Date filed (Month, Day, Year)
DEC 2 6 2

					State of Ma						-		egible.	
		•	For State Registrar						te of l			Reg. No.	006	41028
	Physicia	an	1. Decedent's Name (First, M	liddle, Last)	Mari	,					2. Date of De Month	Day	2 (/Yeer	3. Time of Death
	/Medic	al	4a. Facility Name (If not instit	ution give si	Meyell (meet and number)	ens		4b Cib	Town or	Location of Deat	10		ounty of Dea	10:30 (M)
	Examin	er	11 1	wal	(Aus)	1.		10.01	SNA	mys	mos	10.0	N/A	****
	Funeral		5. Social Security Number 220-24-8834	6. Sex	7. Ag	e (In yrs.	last birthday	If Und	er 1 Year Days	If Under 24 Hrs Hours Min.	(Month, Da	th ay, Year)	9. Bi	rthplace (State or Foreign ountry)
	Director	}	Usual Residence of Deceden		W 283F	78	Yrs.				09-10-	-1928		MARYLAND
	yland		10a. State 10b. Con	unty		10c. Cit	y, Town or L	ocation						10d. Inside City Limits
1	Ba-f st	ctor	MD.	N/A					BALTI	MORE C	ITY	-		XX Yes 2 □ No
5	be filed within 72 hours after death with the Maryland lat Hyglene. Id other than "natural", or Items 23e or 28e-f show avent, the Medical Exercitaer must be notified at	Be Completed by Funeral Director	10e. Street and Number 700 WEST	4oth.	STREET			10f. Z	ip Code	21211		10g. Citize	on of What C	-
HAN	death ms 23	neral	11. Marital Status		2. Was Decedent Amed Forces?	Ever in U	.S. 13.	Was Dec		ispanic Origin? (S n, Mexican, Puer	pecify Yes or No)- 14	I. Race - Am	erican Indian,
100	after or Ite	Fur	1 Never Married 2	Marned	Armed Forces? 1 ☐ Yes 2 X X If Yes, Give Year or Dates:	No			ecity Cuba		to Hican, etc.)	1	Black, Whi	ite, etc. WHITE
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and %		Be	17. Father's Name (First, Mid		RNEST	SHERI	MΔN			18. Mother's Nar		, Maiden Si TMAN	umame)	
Revill Maryland	should ind Men marke umatic	ဥ	19a. fnformant's Name/Relat				,	ina Addre	ss (Street a	and Number or Ri			Town State	Zip Code)
	alth a		ELIZABETH A.B	ARINGE	R (DAUGH	TER)	1745	1 BL	ACKWO	OD ROAD,	GUYSVIL	LE, C	HIO,	45735
イルデア altimore	ges 1 and 2 should tt of Health and Mer If Item 27 is marks or other traumatic		20a. Method of Disposition 1 Burial 2 Cremat	ion 3 □Re	moval from State	0	Place of Disp emetery, cre	matory or	other plac		Date 2006			Town, State YLAND, 21204
III &	Pa Intra		4 □Donation 5 □ Othe	r (Specify)		HII	LTOP			01(1 .	20-2000			
Bal	permit. Departr Importa any inju		21. Signature of Funeral Ser	vice License	。 -(R. G. R	UTH)	R	UCK 1	FOWSO!	s of Facility N FUNERA	L HOME, I	NC. T	.050 YO	ORK ROAD ,MD.21204
' · ' 			23a. Part1. Enter the disease shock, or heart failure.	e, or complic	ations that caused	the deat							ONSON	Approximate Intervat Between
	Physician		Immediate Cause (Finaf disease or condition	List only on	0 04450 011 04011 111	Se	P325							Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as	a conseq	uence of):							
7.		ē	Sequentially list conditions, if any, leading to immediate	b.	Due to (or as	a conseq	uence of):		-74					
5 4	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	1.										
30,	te be executed ysician and e burial-transit		resulting in death) Last	ı	Due to (or as	a conseq	uence of):							
5:3	9 4 9	dicai		d.										
-//c Box 6	n certif anding use a	n/Me	fF FEMALE: 23b. Was decedent pregnan	23	kc. If yes, outcome							23	d. Date of de	livery
, B	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			□Ectopic □ Other (s	pregnancy specify)				Month	Day Year
9 G.	hat the d by ti	Phy	9 ☐ Unknown Part II. Other significant con	ditions cont		ut not roc	ulting in the	undoch sing	001100 0111	no in Bort I	22a Did	obacco uco	o contributo (o the cause of death?
ds,	wrequires that the d been signed by the should be detached	d by	raith. Other signmeant con	ditions com	induing to death b	ut 110t 145	umig in tile i	uridenying	cause give	en ai Faiti.			_	robably 4 Unknown
- 7	w requ	iete			· · · · · · · · · · · · · · · · · · ·						24a. Was	an	24b. Were a	utopsy findings available
ス・3 チーマッ Vital Records,	The lav	Completed									auto perfo	ormed?	prior to death? 1 ☐ Yes	completion of cause of
Z. /ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to me examiner?			N			Var		ath Check only			
of o	Physi this o	7	1 Yes 2 D 16	i Ho	spitaf: 1 Dispatie		ER/Outpatie			4 🗀 Nuising i	lome 5 Resi			ecity)
lon	Attending r death. actor: After	tion	1 Naturaf 5 □ Pe	nding estigation	28a. Date of Inju (Month, Day	Year)	Injury	М	28c. fnjury Work	(? Yes 2 ∐No	200. 2000.1100	now injury (ACCUIT BO	
Division	r Atta	Certification:	3 Suicide 6 Co	uld not be termined	28e. Place of fnji	ury - At ho	ome, farm, si	treet, facto	ry, office		28f. Location (City or To	Street and i	Number or R	tural Route Number,
Ō	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		00- 0-48					V 10 10 10 10 10 10 10 10 10 10 10 10 10						
	A Hosa	Medical	29a. Certifier 1 cert (Check only 2 Med	ical Examin	er: On the basis of and manner sta	examina	wtedge, deat tion and/or in	th onnuire nvestigatio	d at the time in, in my op	na, data and plane pinion, death occu	and due to the irred at the time,	date and p	lace, and du	e to the cause(s)
	To the To the Complex	Me	29b. Signature and title of ce	rtifier			-	2	9c. License	number		29d. Date	signed (Mon	th, Day, Year)
				12	res	4 /	1		1	T2 438	946	()	4241	66
	10		30. Name and address of per	MA 1	/ 10	eath (ften	23a) (Type	, Print)	or open	14-5				
	Sta	te.	31. Date filed (Month, Day, Y		32 Registr	ar's Signa	ture	will	4 /4	M. CONV				
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			For Stata Registrar	. 10000	State of		ind / Dep		t of H	lealth a	and M	lental Hy		200	5	41029
			1. Decedent's Name	(First, Middle, Las	st)		-					2. Date of D				3. Time of Death
	Physici /Medio		Jean-Gu	y Marcou	yeux							Decemb	per 2	23, 20	₀₀₆	4:30P M
	Examir		4a. Facility Name (II	not institution, give	e street and nun	n <i>ber)</i>		4b. City,	Town, or	Location	of Death		40	. County of	Death	-
£ 1				n Hospit					hesc	la	0.111			Monte	ome	ry
0	Funeral		5. Social Security N	1	ex XDM 2□F		s. last birthday 5 Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bi	irth ay, Year	9		lace (State or Foreign try)
4:30	Director		578-86-30 Usual Residence of	Decedent		0	5					June 2	<u> 25, 1</u>	921	rar	nce
	Manyland -f show lied at		10a. State	10b. County		10c. (City, Town or I	ocation	-						1	0d. Inside City Limits
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3	th the	lrec	10e. Street and Nur				•	10f. Zip	Code				10g. Ci	itizen of Wha	at Cour	ilry?
12/23/06	23a	Funerai Director	8100 Cor	necticut					0815					ance		
Ce	er deg	une	11. Marital Status		12. Was Dece Armed Fo	rces?	U.S. 13	Was Dece	dent of Hi cify Cuba	ispanic Or ın, Mexicai	igin? (Spi n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black,		
36	s afte	by F	1 ☐ Never Marri 3 ☐ Widowed	ed A Divorced	1 ☐ Yes If Yes, Giv Year or D	/B ¯ ¯		1 🗆 Yes	2X No	Specify:	:			Specify:	T 71_	: + _
, 	hou	pa		15. Decedent's Ed	L		16a. Dec	edent's Usu	al Occupa	ation			16b. F	Kind of Busin		ite dustry
25	on 72	piet	(Speci	ify onfy highest gra	completed) College (1	Infor 5+)	(Giv	e kind of wo DO NOT u	se retired	during mos f)	st of work	ing				·
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TOB	al Hy I othe	Bec	17. Father's Name	(First, Middle, Last))					18. Moth	er's Name	e (First, Middle	e, Maidei	n Surname)		
> a	Ment Ment arked	ဥ	Albert	Felicien	Marcou	veux				J	eann	e Fouh	ety			
CCCNY CUX, Jean 3altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other treumatic event, Item Juriel Examiner must be notified at once.	0.0	19a. Informant's Na				19b. Ma	ling Address	s (Street a	and Numb	er or Rura	al Route Numi	ber, City	or Town, Sta	ate, Zip	^{Code)} 20815
	and fealth om 27			Marcouy	eux/Wif			Conne	ctic		venue	e, Apt.	62	5, Cho	VY	Chase, MD
3 5	ges It of F		20a. Method of Disp Murial 2	Cremation 3]Removal from	State C	cemetery, cr	ematory or o	other plac	:ө)	Dece	mber			-	
なてこるとと Baltimore,	t. Pa rtmer rtant:			5 ☐ Other (Specif			Cem	etery		5	28.	2006	Si	Lver S	pri	ne, Mo neral Home/
Bal S	Depa Impo any ir		21. Signature of Fu	neral Service Licer	Xa A	140	oooc B	ethese	la-Cl	VVV	Chas	e. Inc.	. Pur	iphrey 557 Wi	SCO	neral Home/ nsin Avenue
<u>-</u>			23a. Part1. Enter a shock, or head	ne disease or com	plications that o	aused the de	Path. Do not a	ethese	la N	Jary 1	and	20814-	-3591	1		Approximate
	-		shock, or hea	rt failure. List only	one cause on e	ach line.	1		-1	j, 4555, 46						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	n	a	(or as a cons	vas cula	r a	-ceid	ent					-	
	Examiner					(01 83 8 6013	equence or).									
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oʻ	e exe ian ar urial-t		resulting in death)	Last	Due to	(or as a cons	equence of):									
8760,	ate be hysicia the bur	lical		•	d											
k 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:													
Box	ath cu	ian/	23b. Was deceden in the past 12			oirth 2 🗆 F	etel death 3	□Ectopic p						23d. Date of Month		ny Day Year
	he de the a	ysic	1 ☐ Yes 2[9 ☐ Unknown	No	4⊟ Pregr 9⊟ Unkn	nant al time o own	r death 5	Other (s	оесту)							
۵.	that the ed by detact	H.	Part II. Other signif	ficant conditions	contributing to de	eath but not r	resulting in the	underlying o	cause give	en in Part I	t.	23e. Did	tobacco	use contribu	ute lo th	ne cause of death?
ds,	ures sign ld be	d by	CHF,	Deep V	ein thro	mb asi	H ₄	Perten	cion			1 🗆	Yes 2	2 □ No 3	Prob	ably 4 Dunknown
S	w req beer shou	ete	Λ .		- 1 1		_,	(Р)		24a. Wa		24h We	re auto	psy findings available
Re.	The law cate has page 2 :	Completed	- Hhe	this -	Dehydr	MACH	, Mult	orga	n 5	anlyre		auto	opsy formed?	prio dea	ir to coi	inpletion of cause of
a	10 0		25. Was case refer	red to medical					-	OF Plan	a of Dogst	1 ☐ Yes		0 1	Yes	2□ No
Ξ	Physician: r this certific ral director,	To Be	examiner?		Hospital:	Inpatient 2	☐ ER/Outpati	ent 3∏ D(Oth Oth			me 5 Res		6 □Other	(Specifi	v)
Division of Vital Records, P.O.	ding Physician: h. After this certific funeral director,		27. Manner of Deat	h		of Injury th, Day Year)		of :	28c. Injun	y at		28d. Describe			(Dpoon)	·
Ö	Attending or death. actor: After by the fune	atio	1 Natural 2 ☐ Accident	5 Pending investigation		ai, Day 10ai)	injury	М		Yes 2	No					
<u>vis</u>	r Atte er de racto by th	tific	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	286. Place	of Injury - At	t home, farm, :	treet, factor	y, office			28f. Location City or To	(Street a	nd Number	or Rura	l Route Number,
ā	italo rs aft ral Di	Certification:				1/1										
	Hospi 24 hou Funer tely fill	Medical	29a. Certifier (Check only	1. Certifying Ph 2 Medical Exam	miner: On the b	asis of exami	knowledge, de ination and/or	ath occurred investigation	l at the tin n, in my o	ne, date ar pinion, dea	nd place, ath occuri	and due to the red at the time	e cause(s , date an	s) and mann nd place, and	er as si I due to	ated. the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Med	one) 29b. Signature and	title of certifier	and man	ner stated.		29	c. Licens	e number			29d. Da	ate signed (/	Month,	Day, Year)
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	no		30. Name and addi	ress of person who			tem 23a) (Tvn	e, Print)	112 - 1	- 0	V 1		, ,	1231	0	
	2			in Akhon					orge	town	Road	. Beth	esda	. Marv	land	1 20814
	St	ate	31. Date filed (Mor	ith, Day, Year)	32 F	Registrar's Sig	gnature		-v-6c	- DOWLL		الما عاد و		- 9 - 11 - 1 - y -		
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		1 - For State Registrar	State of N		Depa		t of H	ealth a		ntal Hy		106	41030
		Decedent's Name (First, Middle, La	st)						2	2. Date of De		000	3. Time of Death
Physic	ian		Charles	Alden	Mil:	1 0 20			1	Month Decembe	er 19,	Year	
/Med		4a. Facility Name (If not institution, given			rii.		Town or	Location o		recembe		2006 nty of Death	4:00 P [™]
Exami	ner			()		40. City,						•	
		618 Nelson Str		han the sum land	for land to select a col	If Under		ckvil		Data of Die		tgome	
Funeral		5. Social Security Number 6. S	M 2□F	Age (In yrs. last 81	Yrs.	Months	Days	Hours	Min.	B. Date of Birt (Month, Da	v, Year)		ptace (State or Foreign intry)
Director		310-12-3099		01	113.				J	anuary	3, 1925	Ohic)
P		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	ocation							10d. Inside City Limits
aryla eho	-												1 X Yes 2 □ No
₩ 9- F	Sch	Maryland Montgo	mery	Ro	ckvi								
or 2	i i	10e. Street and Number				10f. Zip					10g. Citizen	of What Cou	intry?
23a	<u></u>	618 Nelson Stree	et				20	0850			Unite	d Sta	tes
be filed within 72 hours efter death with the Maryland tal Hygiene. Id other than "nature!, or itema 23a or 28a-f show event, the Medical Examination was the multiple at	Funeral Director	11. Marital Status	12. Was Deceder Armed Forces		13.	Was Deced	ent of Hi	spanic Orig	gin? (Speci	fy Yes or No can, etc.)	14. F	Race - Amer Black, White	
or it	교	1 Never Married 2 Married	1 X Yes 2 [If Yes, Give		ŀ				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Jul., 515.7			
er',	by	3 Widowed 4 □ Divorced	Year or Dates	: WWII		1 ☐ Yes 2	M IND	Specify:			Spe	cify:	White
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ntary france Lize Cook	E O	Zidindinaly, occordaly (c. 12)	5+	,	Cel:	L Biol	ogis	st			Fede	ral G	overnment
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2 should be filed and Mental Hygi ie marked other aumatic event,		Frederic Mille	er					Mar	v Wv	song			
should ind Men marks	은	19a. Informant's Name/Relationship	Type Print)	1	Oh Maili	na Address	/Stroot a			Route Numbe	r City or To	em Stato 7	in Cada)
12 s h an 7 ie	4	Timothy Miller				_					-		D 20882
			7 5011						-				
1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from Stat			osition (Nam matory or ot			ecemb		20c. Locatio	on - City or I	own, State
permit. Pages 1 al Department of Hea Important: if item any injury or othe	1	4 □ Donation 5 □ Other (Speci		Montgo	mery	Cremato	rium,	Inc. 2	2, 20	06	Bethes	sda, M	laryland
partit.		21. Signature of Funeral Service Lice	nsee		2	2. Name and	d Addres	s of Facility	у	/.			
Depa impo	1	Ungelattelas	rout	M01305	$\frac{1}{30}$	obert A. O West	. Pum Monts	pnrey i	Funera. Avenu	L Home/l P. Rocks	KOCKVIL Mille, M	le, Inc	i 20850–2805
		23a. Part1. Inter the disease, or com shock, or heart failure. List only	plications that caus	ed the death. D)	Approximate
25.		shock, or heart failure. List only Immediate Cause (Final											Interval Between Onset and Death
Pnysician /Medical		disease or condition resulting in death)	а	static E		ier Ca	incei	:					3 Months
Examiner			Due to (or a	is a consequent	ce of):								
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₽ #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	is a consequent	oe ut):								
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that the death certificate of by the attending phys detached for use as the	by Physician/Medi												
attendin for use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			7					23d.	Date of deliv	very
Jeath a atte	Cia	in the past 12 months?		2 Tetal dea at time of death		∃Ectopic pre ∃ Other (spe						Month	Day Year
hat the d d by the letached	ysi	9 Unknown	9□ Unknown				.,						
requires that the	4	Part II. Other significant conditions	contributing to death	but not resulting	g in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use co	ontribute to	the cause of death?
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lor Attending Physician: The law requires taller death. Director: Atter this certificate has been signed in by the funeral director, page 2 should be to	tec								_		65 2 110		Outly 4 Donationin
as by strain	ompieted									24a. Was			opsy findings available
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ician: Th certificate rector, pag	e C	25. Was case referred to medical						26 Place	of Death (Check only o		10103	20,10
S Cer	0 8	examiner? 1 ☐ Yes 2 🕅 No	Hospital:	tient 2 ER/	Outpation	nt 3 🗆 DO.	Othe			5 🛚 Resid		Other (Care	4.3
Attending Physician: r death. ector: After this certific by the funeral director.	- T	27. Manner of Death	28a. Date of In		outpatier o. Time o		Bc. Injury			d. Describe h			(Ty)
Affe Ting	o	1 X Natural 5 ☐ Pending	(Month, E	ay Year)	Injury	м	Work	:? ∕es 2 ∐ N		G. 0000/100 /	ov injury ood	, a o a	
tor:	Certification;	2 Accident investigation 3 Suicide 6 Could not be						185 2 1					
or All	E	4 Homicide determined	200. Flace of 1	njury - At home, etc. <i>(Specify)</i>	, tarm, sti	reet, factory,	, office		28	f. Location (S City or Tox	itreet and Nu m. State)	m <i>ber or Aur</i>	al Route Number,
is a selection of the control of the	Ö	1											
Hospital - 24 hours a Funeral Distely filled i		29a. Certifier 1X Certifying Pl	ysician: To the bes	st of my knowled	dge, deat	h occurred a	at the tim	e, date and	d place, an	d due to the	ause(s) and	manner as	stated.
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	(Check only 2 Medical Exa	miner: On the basis and manner:	oi examination stated.	ario/of in	vestigation,	in my op	inion, deat	ui occu rred	at the time,	Jate and plac	e, and due t	to the cause(s)
To the I within 2 To the I complet	Σ	29b. Signature and title of certifier				29c.	License	number			29d. Date sig	ned (Month,	Day, Year)
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Y\		20 Name of the state of the stat	and the state of t	I de autorio de la composición del composición de la composición d	->			1	,		141	NI	2004
207		30. Name and address of erson who		death (Item 23: Concord			非さいい	V ~~	neinai	top M	27371 00	4 2080	35
1		Kelly Mercer, M.I				eet,	11 3 U C	, kei	rering	COH, M	aryran	u 2005	
	ate	31. Date filed (Month, Day, Year)	32 Hegis	trar's Signature									
Regist	ırair	DEC 2 6 20	JO Marie	ar a signature	1	Ale-							
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Melvin Morning		Please Type or Print in Black In			
Welvin Worthing		1- For State Cer	rtment of Health and Mental F tificate of Death	4000 41	03
Physicia	_	Registrar 1. Decedent's Name (First, Middle, Last)		Reg. No 3. Time of De 2. Date of Death 3. Time of De	eath
Medical Examir		MELVIA	MOINING	Month Day Year 1308 hr	S
and the same		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	th 4c. County of Death	
		Johns Hopkins Hospital	Baltimore	- In Date of Birth and appropriate of the state of the st	
Funeral Director		5. Social Security Number 10 6. Sex 7. Age (In yrs. la	Months Days Hours Mi	in. Foreign	or
Director	ŀ	Usual Residence of Decedent	44 Yrs.	11-19-1962 Country) //2	
any			Town or Location	10d Inside C	City Limits
ind show	٦	MD BA	11 MORE	1 Yes	2 No
Maryla 28a-f	Director	10e. Street and Number	10f Zip Code	10g. Citizen of What Country	
		3/15 MARY ALE	2/2/4	USA	
ith wir	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	 13. Was Decedent of Hispanic Origin? (\$\frac{1}{2}\$ If Yes, specify Cuban, Mexican, Puerly 		ack,
ter dez		Never Married 2 Married 1 1 Yes 2 No 1 Widowed 4 Divorced If Yes Give Year	1 Yes 2 1 No specify:	Specify: BIACH	
urs aff	d b	or Dates:	16a. Decedent's Usual Occupation (Give kind or	f work done 16b. Kind of Business/Industry	
6 72 ho m "ma	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re	Para Carlo	
5-0036 led within 7 Hygiene. other than	Completed	12		WHYE HOUSE	=
15-(te filed tal Hyg rked oth nt, the	Be	17. Father's Name (First, Middle, Last)	TAYLON EUNIC	ne (First, Middle, Maiden Surname)	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Merital Hygiene tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner	TO B	19a. Informant's Name/Relationship (Type, Print)		r Rural Route Number, City or Town, State, Zip Code)	
MD d 2 sho lth and n 27 is		EUNICE MOUNIS	3115 MAIY AUE	BAltoMB Z1214	
Fe, Fand Heal			Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State	
MOF Pages sent of ant: If or other		4 Donation 5 Other Specify:	Rinity CEM 12	-22-06 BAlto MA	
Baltimore, pe mit Pages I an Department of Hea Important: If ite		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	BAITIMOLE MP 2/2/3	3
	- 11	3a Part I. Entir the disease, or complications that caused the death.		40RO 2431 F. OliVERS-	}
Physician /Medical		failure. List only one cause on each line		Between O	nset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Narcotic intoxica Due to (or as a consequence of			
The same of		Sequentially list conditions, b.			
	ine	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause	f):		
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0, e be ev sician burial	Physician/Medical	X UNPENDED X AMENDED #23a,21,2 #7, perf	28a-f, perME, 9863, 1/5/07 T H, G862, 12/26/06 TT		
68760, certificate be nding physici	W/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregr	nancy Petal death 3 Ectopic pregi	23d. Date of delivery nancy Month Day	Year
OX 68: sath certifi attending	sicia	4 Pregnant at time of de	ath 5 Other (Specify)		
Box. the death of the death of the attenthed for us	hy	Part II. Other significant conditions contributing to death but not re	sculting in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of c	death?
ires that the signed by a signed by a be detached	þ		southing in the underlying educe given in rate.		Jnknown
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tal Rection: The certificate ector, page		25. Was case referred to medical	26 Place of Death (Chec	1 Yes 2 No 1 Yes 2 k only one)	No
of Vital Records, ng Physician: The law require. Ther this certificate has been si meral director, page 2 should be	o Be	examiner?	Other	sing Home 5 Residence 6 Other:	
ding Ph	\vdash	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ion ttendi feath tor: /	atio	Natural 5 Pending Prod 12/16/2006	Fnd 12:15 pm 1 Yes 2 X No	unknown	
Division tal or Attendir rs after death al Director: A	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At ho	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Num or Town, State) 3900 Erdman Ave.	nber, City
Divisior Hospital or Attend 24 hours after death Funeral Director:		4 Homicide determined (Specify) House		Baltimore, MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	Medical	29a Certifier Certifying Physician: To the best of my knowledge (Check only one) Wedical Examiner: On the basis of examination a		d at the time, date and place, and due to the cause(s)	
Vill vill	Mec	29b. Signature and title of certifier	29c. License number	29d Date signed (Month, Day, Year))
		Mayriota Me Malle	O.C.M.E.	December 17, 2006	
9		30. Name and address of person who completed cause of death (Item			
, ,	- "	Margarita Korell MD. Assistant Medical Examin	S c	21201	
St Regist	ate	DI C Di C ZIIII COMANAN A	ire y		
1.09101	-	No. will be seen and the seen a			

DHIVIT 17 Rev 1/2001

			For State Registrar	State of Mar	yland / [Departm Certific					giene	11116	41032
			1. Decedent's Name (First, Middle, Last)	,					2	. Date of Dea			3. Time of Death
	Physici /Medic		Mary McVi	cker					0	exemples			5:35 AM
	Examin		4a. Facility Name (If not institution, give s		· · · · ·	1	City, Town, o	or Location of	of Death		4c.	County of Death	
				Bayview			Dalt I	M) (24 Hrs 0	Date of Bird		/A	-1
	Funeral Director		5. Social Security Number 6. Sex 1 233-34-4199	M 200 F	'In yrs. last bii 31	Yrs. Mon			Min.	Date of Birt (Month, Day April	v, Year)	Cou	place (State or Foreign intry) st Virginia
	ס		Usual Residence of Decedent							ALTI	/_#		
	show	2	10a. State 10b. County		Oc. City, Tow								10d. Inside City Limits 1 ☐ Yes ※XXNo
	28a-f	Director	Maryland Baltimo 10e. Street and Number	re	Dunda		Zip Code				10a Citi	zen of What Cou	
	with 3a or	ᅙ		T				2				_	
	me 2;	Funeral	4021 St. Augustine 11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was D	2122 ecedent of I	lispanic Ori	igin? (Specif	fy Yes or No-		ted Stat 14. Race - Amer	ican Indian,
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or iteme 23a or 28a-f show or other treumatic event, the Medical Examinar mutil te notified at	필	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give				an, mexicar Specify:	n, Puerto Ric	can, etc.)		Black, White	
Baltimore, Maryland 21215-0036	ural',	d by	3 Novidowed 4 □ Divorced	Year or Dates:	40-							Specify: Whi	
15	n 72 n "nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)		. Decedent's (Give kind of life. DO NO	f work done	during mos	t of working		16b. Ki	nd of Business/Ir	naustry
212	within jiene. r than "	mo d	Elementary/Secondary (0-12) 10 years	College (1-4or 5+)		ysical	Ther	apist	Aide		Не	alth Car	re
פ	e filed Il Hygi other vent, I	a l	17. Father's Name (First, Middle, Last)			2				First, Middle.	Maiden	Sumame)	
/lar	2 should be and Mental is marked o	To B							a Maud	laude Pudder			
lan	2 sho and is ma		19a. Informant's Name/Relationship (Type	pe, Print)	19t	. Mailing Add	ress (Street	and Numbe	er or Rural F	Route Numbe	r. City o	r Town, State, Zi	p Code)
e, N	1 and Health em 27		Richard McVicker 20a. Method of Disposition	(Son)		844 St		ifaçe	Lane			Marylan cation - City or T	nd 21222
nor	Pages nent of the ant: If ite		1 🖫 Burial 2 □ Cremation 3 □ R	emoval from State	cemete	ry, crematory	or other pla	1					
Ē	글 번번 중 .	1	*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature → Funeral Service License	99.	Holls	Hill 22. Nam		Gdns. ess of Facili		2/2006	Mı	ddle Ri	ver, Md.
Ba	Depa Impo any i		1 handy	y in	Alle							dalk, In	
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the	ne death. Do	not enter the	mode of dyi	ng, such as	cardiac or r	espiratory ar	rest,	rytand	Approximate Interval Between
Į.	Physician	St. 13	Immediate Cause (Final disease or condition									Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a o	consequence	of):	1		,				
	Examiner		Sequentially list conditions,	Cirellovo	ascu		acc	der					
	ted nsit	nlne	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	203 to for as a t	nonsequanca	Oty:							
,	be executed sician end burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a c	consequence	of):							
8760,	death certificate be executed e attending physician end nd for use as the burial-transi	cal		J									
9	rtifica ng ph as th	be	IF FEMALE:										-
Вох	death certifica attending pt d for use as t	lan/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	Fetal death		ic pregnanc	у			1 4	23d. Date of delive	very Day Year
0	the de by the a tached f	hysici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	ne of death	5∐ Othe	r (specify) _						,
σ.	the ed	<u>a</u>	Part II. Other significant conditions cor	ntributing to death but	not resulting i	in the underly	ng cause gr	ven in Part I	l.	23e. Did to	obacco u	se contribute to	the cause of death?
rds,	en sign	ed by								1 🗆 Y	'es 2 (□No 3□Pro	bably 4 🗷 Unknown
Record	s b	ompleted								24a. Was		24b. Were aut	opsy findings available ompletion of cause of
Ä	o ~ o	Com								perfo		death?	2 No
Vital	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						e of Death (Check only o	ne)		
of/	this al dir	2	T Tes 2 140	lospital: 1 Inpatient			DOA					Other (Special	ify)
no	After Anter	tlon	27. Manner of Death 1 ≦Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day)		Time of Injury M		rk?]Yes 2		d. Describe h	iow injui	у оссильа	
Division	of or Attending after death. Director: After	ertification;	3 Suicide 6 Could not be	28e. Place of Injury	/ - At home, fa			_		f. Location (S	Street an	d Number or Rui	ral Route Number,
Ö	s affer of Dire	Certi	4 Homicide determined	building, etc.	(Specity)					City or Tou	m. State)	
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in L	edical (sician: To the best of ner: On the basis of e and manner state	xamination at								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0			29c. Licen	se number		1		e signed (Month	(-
)			Arace a. Co	rottem	10		D35	763		6	rece	meler 1	9,2006
1	7		1.00.01 11	empleted cause of dea	th (Item 23a)	(Type, Print)	: //\` = = :=	1	10	6.11		· im ·	21224
(F			31. Date filed (Month, Day, Year)	5305 /70 32 Registrar'	S Gignature	5 Bay	VIELU	circi	e, L	men	nov	eria.	21224
	Sta Regista		DEC 2 6 200		and the state of	A MARIA	9						

	1 - State Registrar				Cer	tificate of L	Death		eg. No 2	06	4103
ian	1. Decedent's Name (Firs							2. Date of Dear Month	Day	Year	3. Time of Death
ical 🛚	MARION B. 4a. Facility Name (If not in					4b. City, Town, or		DEC.		006 y of Death	12:05a
ner	STELLA MAI					TIMONI	UM		BAL	TIMOR	
	5. Social Security Numbe 220-30-296		x 7.] M 2 ⊠ F	Age (In yrs. last	birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 07/21	. Year)	9. Birthp Coun MARY	lace (State or Foreig try) LAND
	Usual Residence of Dece 10a. State 10b.	dent County		10c. City, T	own or Loc	ation				1	0d. Inside City Limits
tor	MD B	ALTIMO	RE	ВА	LDWI	N					1 ☐ Yes 2 🏋 No
Director	10e. Street and Number	0.D. D.D.				10f. Zip Code	2	1	0g. Citizen of	What Coun	itry?
	13500 MANG	OR RD	12. Was Decede	ant Ever in II S	13 V	2101 Vas Decedent of H		ecify Yes or No-	USA 14. Ra	ace - Americ	an Indian,
by Funeral	11. Marital Status 1 □ Never Married		Armed Force 1 ☐ Yes 2 If Yes, Give	es? X No	"	Yes, specify Cuba	Specify:	Rican, etc.)		ack, White,	etc.
	3 ☐ Widowed 4 ☐ I	Decedent's Edu	Year or Date		l6a. Deced	ent's Usual Occup	ation	. 1	16b. Kind of I		
Completed	(Specify or	nly highest grad	le completed) College (1-4	or 5+)		kind of work done o	during most of worl)		REAL 1	r c m x n	าย
		4	YRS		REAL	TOR	18. Mother's Nam				E
Be	17. Father's Name (First,		TNGHAM					F. REY		uno,	
유	19a. Informant's Name/F				19b. Mailin	g Address (Street				n, State, Zip	Code)
	PHILIP S	• NORM	AN (HUS			O MANOR	RD BAL				
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre		Removal from Sta	oto cem	netery, crer	sition (Name of natory or other place	TON 12/	Date 26 / 06	20c. Location	·	
	4 □ Donation 5 □	Other (Specify)	ST.	JAM	ES MONK		20/00	MONE	XTON,	MD.
	21. Signature of Funeral	Service Licens	nee of	•	Ħ	ENRY W. 6924 YO	JENKIN	S & SOI	NS CO		
	23a. Part1. Enter the dis shock, or heart fail	sease, or comp	lications that cau	ised the death.							Approximate Interval Between
	SHOCK, OF HEART IAII		nie cause on cae	it into.							Onset and Death
	Immediate Cause (Final disease or condition		. CEREB	ROVASCIII	LAR A	CCIDENT					Origet and Death
	Immediate Cause (Final disease or condition resulting in death)		и.	ROVASCU as a consequer		CCIDENT				113	Chief and Death
J.	disease or condition resulting in death)		Due to (or		nce of):	CCIDENT					Origet and Death
miner	disease or condition resulting in death) Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury)	ons, liate	bDue to (or	as a consequer	nce of):	CCIDENT					Chact and Death
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State Registrar

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY RD.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

DEC 2 6 2006

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day . **Physician** DECEMBER 2006 11:50PM Ridgely Kent Otto /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Towson Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F Yrs. 09-21-1943 219-84-0969 Director 63 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show if than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MD Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 U.S.A. 6000 Bellona Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 TNever Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ٥ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Disabled Disabled permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygin Important: If Item 27 Is marked other any Injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leona Pearl Hoffheiser Francis Loran Otto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Metro Drive; Baltimore, MD 21215 Ms. Cheri Whitaker / manager 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Chesapeake Cremation | 12-22-2006 | Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home, PA 21, Signature of Funeral Service Licenses 1 Second Ave SW; Glen Burnie, MD 21061 MU1357 rance 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, the art failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** CARDIAC ARREST resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any district in immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine death certificate be executed as the bunal-transit and Due to (or as a consequence of): attending physician for use as the buna Physician/Medical IF FEMALE: asn 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ned by the a detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 24 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☐ Yes 2 ER/Outpatient 3 □ DOA 1 Inpatient 2 funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760 Division or Vital Records.

> State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

1717 DAZI

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D 59855

🔯 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE, TOWSON, MARYLAND 21204 7601 QINGLIN GAO, M. D

31. Date filed (Month, Day, Year) DEC 2 6 2006



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 21, 2006 Physician P M 4:41 Aaron Henry Otto /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hospice of Baltimore Gilchrist Ctr. Towson 8. Date of Birth (Month, Day, Ye Feb 10, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1√1 M 2□ F 1915 Pennsylvania 91 202-07-8793 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mass the marked of the property or other traumatic event, the Medical Examinar mass the marked of the property in the Medical Examinar mass the marked of the property 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21210 100-B Cross Keys Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Specify Maryland 21215-0036 Specify. \$ white 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Television Producer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Viola Schwalm Harry Emerson Otto ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100-B Ridgewood Road; Baltimore, MD 21210 Gregory Scott Otto son Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State Hilltop Service Corp.:12/23/06 Towson, MD 4 ☐ Donation \ 5 ☐ Other (Specify) 1050 York Road 21. Signature of Fuheral Service License 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one juse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AnomA **Physician** ars /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause for the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown s been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>^</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has le 2 autopsy performed2 page 2 1 No certificate Hospitai or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 **N**o 1 Inpatient 2 ER/Outpatient 3□ DOA ဥ After this c funeral din 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

107

State Registrar 30. Name and address of person who completed dadse of death (Item 23a) (Type, Print)

6

6701 N-C

1)25205

N-Charles St. Balto, Md 21204

December 21,2006

			For State Registrar	State of Maryland		artment of F <i>rtificate of</i>			giene Reg. No. 2008	41036
. 🔻		*	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea		3. Time of Death
	Physici /Medic		Rosemary Stolz	Owen				Decemb	er 19, 200	6 4:35P ^M
	Examin	3.6	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death	1	4c. County of Dea	ath
	Funeral		Wilson Health C 5. Social Security Number 6. S			Gaith If Under 1 Year Months Days	ersburg If Under 24 Hrs. Hours Min.	8. Date of Birt	Montgom	ery nhplace (State or Foreign ountry)
glister - "	Director		546-28-6210 Usual Residence of Decedent	85	Yrs.			Feb. 2	.8 , 1 921 Ca	lifornia
land	A II		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
Mary	불	ţ	Maryland Montgom	ery Gai	.thersb	uro				1X Yes 2 □ No
the	or 28a-f show as notified at	rec	10e. Street and Number	CLy dar	CITCLOL	10f. Zip Code			10g. Citizen of What C	ountry?
h with	23a o	a D	415 Russell Aven	ue. Apt. #109		20877			United Sta	tes
deat	ama i	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.		Was Decedent of H	Hispanic Origin? (S an, Mexican, Puert			erican Indian,
after	a a	y Fu	1 Never Married 2 Married	1 Ves 2 No Wor	.1.4	1 ☐ Yes 2 🛭 No		o moan, etc.,	Spanifur	
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and 2	if Health and Mental Hygiene. Item 27 Is marked other than "natural", or itsma 23a or 28a-f shov other traumatic svent, Tre Medical Examinar must be notified at		Nancy Owen/Daugh	iter	349 M	Morris Av	enue. Pro	ovidence	Rhode Is	land 02906
98 1.8	Department of Health a Important: If item 27 is sny injury or other tra		20a. Method of Disposition	20b. P	lace of Disco	sition (Name of		Date ember	20c. Location - City of	
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DHMH 17 Rev 1/2001

amend item 4a per gs g873 11-8-07 vt.
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Margarita Petrou		- For State Registrar	St	ate of N	/larylan	-	ortment of <i>tificate of</i>		and M	/lental ⊦	-	Reg. No. 2(006	4103
Physician Medical Examine	1	1. Decedent's Name Margarita		_{e,Last)} trou							2. Date of De Month	Day Yea		3. Time of Death
January .		4a. Facility Name (if I	not institutio	n. give stree	et and numb	er)		4b. City, Town		ation of Deat		er 21, 2006 4c. County	of Death	
5		5. Social Security Nu		6 Sex		Age (In yrs. Ia	aet hidhday)	Baltimore		Under 24Hr	s 8 Date of F	Birth (MM/DD/YYYY	A Bieth	place (State or
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiems 73 is marked other than "natural", or items 23a or 28a-f should yor other traumatic event, the Medical Examiner must be notified at once.	oΓ	19a. Informant's Nam	e/Relations	OIL IL	Print)		19b. Mailine	Address (S				umber, City or Tow		Zin Code)
MD d 2 shoulth and I is a sumatic	-	Luis M. V		วท	Husber	iend nd ance								ts,NY 11372
or Heal	-	20a. Method of Dispo			emoval from	200.1	Place of Dispos crematory or ot		cemete		Date	20c. Location	City or T	own, State
Baltimore, pernit. Pages I a Department of He Important: If ite		4 Donation 5 21. Signature of Fund	Other S	pecify:	1		etro Cre				/22/06	Catons		•
Bal permi Depar Impo		21. Signature of Fund	eraj Service	Licensee	//	>	22. N	iame and Addi irgee-H	ess of F	s-Seit	z Funei	ral Home, ce. Maryl	Inc	11111
Physician	1	23a Part I. Enter the failure. List only	disease, or one cause	complication each line	ns that caus	ed the death.	. Do not enter t	ne mode of dyi	ng, such	n as cardiac	or respiratory a	arrest, shock, or he	and art	21211 Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Fi	nal disease	a. Hype	ertensive	Atheroscl	erotic Card	ovascular l	Diseas	se				Death
		Sequentially list cond		b.	o (or as a co	risequerice o	1).							
ý o		if any, leading to imm cause. Enter Underl	nediate ying Cause	Due to	o (or as a co	nsequence o	f):							
ted Instit	Exal Exal	(Disease or injury that events resulting in de		Due to	o (or as a co	nsequence o	f):							
ecu am ecu	edical	UNPENDED		X AMI	ENDED 1	1,16a-	19a per	attor	ney	g871	9-19-07	vt vt		
760, icate be exphysician the burial		IF FEMALE: 23b. Was decedent p	reamant in th		c. If yes, out	come of preg	nancy g87	2_10-11	-0 /	vt/dk	782	23d. Date of	delivery	
Box 6876(e death certificate the attending physed for use as the b	clan	past 12 months?		1 4	Live birth	tat time of de	- 44	tal death her (Specify)	3E	ctopic pregr	ancy	Month	Da	y Year
m P Fpl:	Physician/iw	1 Yes 2 V No		known 9	Unknowr									
P.C	2	Part II. Other signific	cant condi	ions contr	ributing to de	eath but not n	esulting in the i	inderlying cau	se given	in Part I.		tobacco use contr es 2 No 3		bly 4 Unknown
rds, require been si	Completed	•									24a. Wa			ppsy findings available
He law ate has age 2 s	d llo										per		death?	mpletion of cause of
tal R cian: 1 certific ector, p	a Re	25. Was case referre examiner?	d to medica	-						eath (Check	only one)			
Physical directions	악	1 ✓ Yes 2 27. Manner of Death		Hospita	8a. Date of	atient 2	ER/Outpatient 28b. Time of		Othe		ng Home 5	Residence 6		Scene
OD C ending ath or: Aff	TION:	1 V Natural	5 Pen	ding	(Month, Da	ay,Year)	255. 711110 51.1			2 No	200. 200015	o now injury occur	ou .	
or Atto fire de Directe in by t	Certification:	2 Accident 3 Suicide	6 Cou	a not be	28e. Place o	f Injury - At h	ome, farm, stre	et, factory, office	e buildi	ng, etc.	28f. Location or Town		er or Rura	al Route Number, City
Di ospital hours a meral y filled	5 -	4 Homicide 29a. Certifier			(Specify)									
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	<u> a</u>	(Check only		miner:On the	he basis of e	xamination a						iuse(s) and manner te and place, and c		
T William	≨⊦	29b. Signature and ti	tle of certific		manner state	su		29c Lic	ense nu	mber		29d. Date sign	ed (Mont	h, Day Year)
		Jas	hal	Lee	el	MO		0.	C.M.E			December	22, 200	16
10		30. Name and address Tasha Green				of death (Item lical Exam		Penn Stree	et, Bal	timore, M	D 21201			
Stat	-	31. Date filed (Month	, Day, Year)		32. Reg	trar's Signatu		4						
Registra	:17		DEC 2	6 200	ti su	Marke All W	17. Ch	Belli						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black indelible ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 19, 2006 22:35 December Robert Leroy Pace /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, Year, Feb. 22, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign al Security Numbe 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 X M 2 ☐ F Feb. 1919 Ohio 87 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at Rockville 1 ☐ Yes 2 No Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 20852 United States of Amer. ms 23a 6111 Montrose Road, Apartment 725 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or items dical Examiner mu Black, White, etc. filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1944–45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Printing Printing Salesman 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t and 2 should be fill Health and Mental H tem 27 is marked oth Marie Coruber Curtis Pace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tran 10101 Baldwin Court, Bethesda, Maryland 20817 Robert E. Pace / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 23. 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 2006 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Servi Rate And Politish Fee Funeral Home/Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, Maryland 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** BILATERAL 12 DAYS /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE EXACERBATION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and s the burial-transit A Pue Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 CONGESTIVE 1 Ves 2 No 3 Probably 4 Unknown CHRONIC RENAL FAILURE page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No DIABETES MELLITIS TYPE IT PROSTATE CANCER 24a. Was an autopsy perform certificate 2 No HYPERTENSION ANASARCA 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After ti 28c. Injury at Work? After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D 053654 DECEMBER 20, 2006 MI completed cause of death (Item 23a) (Type, Print) 30. Name and address ss of person who 20850 9901 MEDICAL CENTER DRIVE ROCKVILLE YAO MD YAO 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 2 6 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- State Registrar

Certificate of Death

1. Decedent's Name (First, Middle, Last)

2. Date of Death

			1 - For State Registrar	Cer	tificate of Death	Reg.	2005 41039
	Physicia	an	Decedent's Name (First, Middle, Last)		3	2. Date of Death	Day Year 3. Time of Death
	/Medic		Crweneth	Kenai		Dec 21	2006
	Examin	er	4a. Facility Name (If not institution, give s	11	4b. City, Town, or Location of Dea	tn	4c. County of Death
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs	Adamsh Day Va	Birthplace (State or Foreign
	Director		580-02-8195 10	M 2□ F 73 Yrs.	Months Days Hours Min	Jan S.	933 Trinidad
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	Maryl f sho	ŗo	hel n/a	Bo. 16 0	nove		1 ☐ Yes 2 ☐ No
	r 28e	irec	10e. Street and Number	1 61	10f. Zip Code	10g.	Citizen of What Country?
	th with	al D	2700 71. Chay	-les St.	21218		U.S.A.
	er dea	Funeral Director	Tr. Maria. States	Armed Forces?	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	irs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2151 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: "Black
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health and Seor 28e-f show item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, It a Medical Examinational Destruited at	ted	15. Decedent's Educ	ation 16a. Deced	dent's Usual Occupation	16b	. Kind of Business/Industry
21215	within 7 iene. 'than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of wo DO NOT use retired)	orking	1
121	filed within Hygiene. other than "		17. Father's Name (First, Middle, Last)	Hom	12 males V	ime (First, Middle, Maid	Domestic
Maryland	d be f antal h red of	o Be	Ost 11 C	shall	1.0	Bath	on Junaney
ary	should be and Mental is marked o	10	19a. Informant's Name/Relationship (Typ	pe Print) 19b. Mailir	ng Address (Street and Number or R	Tural Route Number, Cit	
	1 and 2 Health a em 27 is	1	Charmaine Renaud	daughter 2912	Garrison Pl	vol. aptal	Balto led 21216
Baltimore,	ges 1 and of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place of Dispo	sition (Name of matory or other place)	Date 20c	. Location - City or Town, State
ii m	Pa ant ury		`4 ☐ Donation 5 ☐ Other (Specify)	Irinity	Cemetery Dec	24 2006 13	alto, ad
Bai	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service License	° 7 1	Name and Address of Tocility	and Funer	Led 21217
			23a. Part1. Enter the disease, or complic	cations that caused the death. Do not ent	er the mode of dying, such as cardia	ac or respiratory arrest,	Approximate
	Physician		shock, or heart failure. List only on tmmediate Cause (Final	<i>f</i> .	A	_	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	WAR HOODE	V7	rakacin.
	Examiner		Sequentially list conditions b.	HYPERTENSION	J		UNKraus
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
14	xecution and al-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
,09289	cate be executed physician and the burial-transit		L _d				
89	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Medicai					
Вох	eath cer attendir for use		23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery Month Day Year
O. E	ne dea the at hed fo	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)	· · · · · · · · · · · · · · · · · · ·	Month Day real
۵.	that the died by the detached			tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
ds,	luires tha signed Id be det	d by	SEIZURE DISORde			1 ☐ Yes	2 No 3 Probably ₩ Unknown
Records,	s been si should	Completed	Stan 14 Scral	Deut VICET		24a. Was an	24b. Were autopsy findings available
Re	The law cate has page 2 a	mo	5	with metastatus		autopsy performed 1 ☐ Yes 2 X	prior to completion of cause of death? No 1 Yes 2 No
Vital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	77		eath (Check only one)	
of \	9 0 =	은	1 □ Yes 24 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time of		Home 5 Residence	
ou (ding After fune	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
Division	Attending ir death. ector: Alter by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, str			and Number or Rural Route Number,
ā	s after s afte	Certification;	4 Homicide	building, etc. (Specify)		City or Town, St	are)
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical (29a. Certifier (Check only one) Certifying Phys	ician: To the best of my knowledge, death ler: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the To the To the Comple	Me	29b. Signature and title of certifier	The state of the s	29c. License number	29d.	Date signed (Month, Day, Year)
)			1000	MO.	D005905C	1	2/26/66
	γ			mpleted cause of death (Item 23a) (Type,		·	
			DAI CEFT SALUT	A MO (600 W)	EST MT DUTCE A	Roll	ma 21217

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 6 2006

KENAUD, CIWENTH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State 70f Maryland Angent po Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last **Physician** 15:00 cauls 12 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bal timore Hopkins Bayview Medica Contor If Under 1 Year | If Under 24 Hrs. al Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 💢 F 78 3, Maryland Director 220-18-8261 Mar Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1√2 Yes 2 □ No must be notified MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö death with 505 South 45th Street 21224 items 23a USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner Pages 1 and 2 should be filed within 72 hours after or the to the and Mental Hygiene. 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates: 2 X No 1 Never Married 2X Married ò Baltimore, Maryland 21215-0036 • py ▶ 1 ☐ Yes 2 🔯 No Specify: White 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical unk and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 scaleman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilhelmina Frediricka Koehler Henry John Caison ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 South 45th Street Baltimore, MD Michael Regulski/spouse f Health a other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 20a, Method of Disposition ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once, 4 Nonation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Raltimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S. Wade, Director per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Stooke /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examiner that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Box 68760. physician The law requires that the death certificate be the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. Type 2 No 9∏Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Inknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has birector, page 2 s autopsy death? 1 ∐ Yes 2 **1** No 2 □ No 1∐ Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ۲ Division or this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral C completely filled i Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 265-000 son who completed cause of death (Item 23a) (Type, Print) Name and address of pe MDIPhD 4940 Eastern Ave, Baltimore, MD, 21224

Registrar

State

Day,

Year)

31. Date filed (Mo

Registrar's Signature

06-09614 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Myrna Patricia Romer State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day December 17, 2006 0114 hrs **Medical Examiner** Patrica Myrna 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown Washington County Hospital 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5 Social Security Number If Under 1 Year Age (In yrs. last birthday) **Funeral** oreign Months Days Hours Min Directo 216-82-4269 36 2 X F 1979 Country)Virginia 1 M May 30. Usual Residence of Deceden 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 X No 28a-f show Horntown hours after death with the Maryland Accomac 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country notified at 23395 USA P.O. Box 435 23а Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Yes White Yes 2 X No specify: Widowed 4 X Divorced If Yes, Give Year Specify: ₫ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) 2 should be filed within 72 has and Mental Hygiene.
27 is marked other than "na Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 8 Printer Printing Shop 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) tem 27 is marked traumatic event, t Be Robert Johann Romer Phyllis Phillips Pages 1 and 2 should be ment of Health and Ment taut: If item 27 is mark or other traumatic even 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 211 Lee Street Cumberland, MD 21502 Margery Mishow 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial Important: injury or oth 12/20/06 Scarpelli Crem. Svc. Cresaptown, MD Donation 5 Other Specify. 22. Name and Address of Facility Shaffer-Warnick Funeral Home 21. Signature of Funeral Service Licenses 230 E. Main St. Romney, West Virginia 26757 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure List only one cause on each line /Medical Death mediat - Cause (Final disease condit - n resulting in death) Diltiazem intoxication Examiner Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical g physician a the burial -X UNPENDED AMENDED #23a,27,28a-f,perME,g863, 1/2/07 TT Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Ectopic pregnancy Live birth Fetal death Day nast 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed l be deta ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes Hospital or Attending Physician: 26.Place of Death (Check only one) 25 Was case referred to medical Be examiner? Other₄ Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Nursing Home 5 Residence 6 DOA After this 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Manner of Death 28c. Injury at Work Certification: Natural 1 Yes 2v No 5 Pending Director: unknown unknown unknown Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide determined (Specify) unknown Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the

State

Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d Date signed (Month, Day, Year)

December 17, 2006

and manner stated

mo

30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Richardson Jr December Alfred Nathan ,2006 5 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) NA Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 12 22 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Year) 63 42 212-42-6775 Usual Residence of De 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 3716 Park Heights Ave 21215 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐ Yes 2X No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Home Improvement 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nathan A. Richardson Daisy Dockins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3822 Greenspring Ave, Baltimore, Md 21211 Agnes Griffin-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion 12/22/06 Baltimore, Md 23a. Part lEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Baltimore, Md 21215 Approximate Interval Between Onset and Death 3 Weeks Preummia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of):

Physician /Medical **Examiner** The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

ģ

Completed

item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified

and Mental Hygiene.

Department of Health a Important: If item 27 Is any injury or other tra

iled within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

Examiner and burial-tran been signed by the attending physician should be detached for use as the buria Physician/Medical Be Completed by page 2 funeral director, Certification: To After this within 24 hours after death To the Funeral Director: . completely filled in by the i

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 É	es, outcome pf pregn Live birth 2 □ Fet Pregnant at time of a Unknown	al death 3□Ect	opic preg ner <i>(sp</i> ec			23d. Date of Month	delivery Day	Year
Part II. Other significant condition	ns contributir	g to death but not res	ulting in the under	lying cau	se given in Part I.	23e. Did tobacc		e to the cause Probably 4	of death?
						24a. Was an autopsy performed	prior death	autopsy findin to completion on? 'es 2 \sum No	gs available of cause of
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospita	1 Thpatient 2]ER/Outpatient 3	B□ DOA	Othor	eath (Check only one) Home 5 Residence	6 □Other (S	pecify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigs		Date of Injury (Month, Day Year)	28b. Time of Injury	280 M	i. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred		
3 ☐ Suicide 6 ☐ Could no determin		Place of injury - At h building, etc. (Speci		factory,	office	28f. Location (Street City or Town, St	and Number or ate)	Rural Route N	lumber,
	xaminer: O					ce, and due to the cause curred at the time, date			se(s)

Hospital or Attending Physician:

the

State Registrar

Medical

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

December 15, 2006 Memorial Hospital,

Union

31. Date filed (Month, Day, Year) DEC 26

29b. Signature and title of certifier

32. Registrar's Signature

					of, tate 196	Marylaı , goo2	nd/Dep 12/26/06	artmen rtificat	nt of H	ealth a	and M	lental Hy	giene Reg. No	2006	Trease of	1043
	Physici /Medi		1. Decedent's Name (First, Mic PRENTI	2	Kok	BIN.	No					2. Date of De Month	Day	0 b		Time of Death
	Examir	ner	4a. Facility Name (If not institut							Location of	of Death		4c.	County of D	eath .	
1 3 3 4 4 A			Good Samar 5. Social Security Number	itan 6. Se			. last birthday)		altin r 1 Year	If Under	24 Hrs.	8. Date of Bir	th	NA	Righnlace	(State or Foreign
- D	uneral irector		213-26-9157 Usual Residence of Decedent]M 2□F	73		Months		Hours	Min.	(Month, Da 1–17-	y, Year)		Country)	S.C.
Maryland	s-f show	tor	10a. State 10b. Cour		ΙA	10c. C	ity, Town or Lo Balt	imore	9				-			Inside City Limits 1 Yes 2 No
h with the	23a or 28a at be not	al Director	10e. Street and Number 2020 E. 31st	Str	eet			10f. Zip	Code 21218				10g. Citi	zen of What USA	Country?	
:1215-0036 within 72 hours after death with the Maryland	i riseint and weiten hygerie in gettien 23a or 28a-f show filen 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exactinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ M 3 🌠 Widowed 4 ☐ Divorce	arried	12. Was Deced Armed Ford 1 1 Yes 2 If Yes, Give Year or Dat	es? □ No		Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.))-	14. Race - A Black, W Specify: B	hite, etc.	ndian,
21215-0036 ad within 72 hours af	e. an "natur Medical	Completed	15. Deced (Specify only high Elementary/Secondary (0-12	est grad		for 5+)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT u	rk done a	furing most	t of worki	ng		nd of Busine		•
N D	ther th		12th grade 17. Father's Name (First, Middi	a (ast)	2 yrs.		Cas	ter C	Coord	linato		(First, Middle,		hlehe	m Ste	eel
Maryland d 2 should be file	and mental hygiene. Is marked other than "raumatic event, the Mar	To Be	Donnie			Rok	oinson			Ora	ì			Peter		
and 2 st	27 ts r traun		19a. Informant's Name/Relation Eraina Burge			ghter						Baltim	-		a, <i>Zip C</i> od 2121 8	
G S	D		20a. Method of Disposition 1, Burial 2 Crematio 4 Donation 5 Other	n 3 □ P		20b.	Place of Dispo	sition (Nar natory or o	me of other place	T	0	Date	20c. Lo	cation - City		
Baltir P	important: I eny injury o once.		21. Signature of Funeral Service		wa	ne_		. Name ar	nd Addres	s of Facility	у	27-06 March l Baltin	F.H.		2120	
A second	/sician ledical		23a. Part1. Enter the disease, shock, or heart failure. L tmmediate Cause (Final disease or condition resulting in death)	or complist only or	CF	D line.		er the mod	de of dying	g, such as	cardiac c	or respiratory ar	rrest,		Inte	proximate erval Between set and Death
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ecords, P.O. BOX 68/6U, law requires that the death certificate be executed	by the attending physistached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2		h 2 ☐ Feta nt at time of o	aldeath 3□	Ectopic pr Other (sp					2	3d. Date of o	delivery Day	Year
rdS, F	gned be de	þ	Part II. Other significant cond	tions cor	ntributing to dea	th but not res	sulting in the u	nderlying c	ause give	n in Part I.			obacco u			use of death?
r e	certificate has been si rector, page 2 should	Completed												24b. Were prior t death 1 \(\text{ Y}	o complet?	indings available tion of cause of
OT VITA Physician:		o Be	25. Was case referred to medic examiner? 1 \(\sum \) Yes \(2 \sum \) No		lospital:		3ED/0		Othe	r		Check only o				
	After this funeral di	H- 1	27. Mann of Death 1 atural 5 ☐ Pend	ling stigation	28a. Date of (Month,		28b. Time of Injury		Bc. Injury Work	4 L Nui	2	ne 5 🗆 Resid 28d. Describe h			oecify)	
	Director: A	Certification:	3 ☐ Suicide 6 ☐ Coul	-	28e. Place of building	Injury - At h , etc. <i>(Speci</i>	ome, farm, str fy)					28f. Location (S City or Tow		Number or	Rural Rou	ute Number,
le Hospital	To the Funeral Directions of the Completely filled in b	edicai C	29a. Certifier Check only one) Certifier 2 Medic	ing Phys al Examir	sician: To the b ner: On the bas and manne	is of examina	ation and/or inv	estigation,	, in my op	inion, deat	h occurre	ed at the time, o	date and	place, and d	ue to the	cause(s)
To the	To th comp	Me	29b. Signature and title of certif	ier				290	: License	number	7	(M)	29d. Date	signed (Mo	nth, Day,	^{Year)} 2/17/2006
	12		30. Name address of person	n who co	mpleted cause	of death (Ite	m 23a) (Type,	Print)	100	- P	1000	1 1/11) 2	1239	U	
	Sta Registr		31. Date filed (Month, Day, Yea	6 20	06 32 Aeg	pistrar's Signa	ature		CEVVCA	· 1,3	VV	1	, 51	,/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Kobinson 11:13 KM Shirley 2006 12 /Medical 4b. City, Town, or Location of Death
Combined Maryland 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital Dorchester. Dorchester General If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 25) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 193<u>7</u> 1 ☐ M 2 🗑 F Yrs. 214-34-9144 69 Maryland Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f ehow 1 ☐ Yes 2√ No Directo MD Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4401 Richard Way 21643 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 X Widowed 4 ☐ Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 nurse aide healthcare Ith and Mental Hygir 27 is marked other r traumatic event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Merritt Edward James Pritchetts Sr Pages 1 and 2 should nent of Health and Men ပ္ Wilhemina Tyvola Woodland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johney Robinson/son 4401 Richard Way Dorchester, MD 21643 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ortant: # i 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☑ Other (Specify) Departi Importa any nj 21. Signature of Euneral Servi 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

23a. Party. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aspiration hours /Medical Due to (or as a con equence of): Examiner Scisis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Peritonitis Bacteriul Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e Division of Vital Records, P.O. 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be de-Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

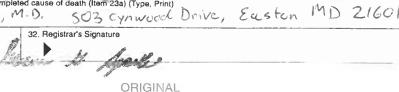
To the Funeral Director: Al
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

(an

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Weinstein, M.D.



M.D.

29c. License number

00063802

29d. Date signed (Month, Day, Year)

12/2006

			riease	State of Maryla					•		
		-	For State	State of Maryla	•		e of Death			2006	41045
·			Registrar 1. Decedent's Name (First, Middle, Last)		1111001	o or boati.		2. Date of Death		3. Time of Death
	Physicia	50	Raymond B.	Sersen					Dec 17	Day 2006	3:30a _м
	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Location of	of Death		4c. County of Deat	h
			3802 Chestnut				Middle			Balti	
	Funeral		5. Social Security Number 6. Se 218-09-2939	x 7. Age (In y	rs. last birthday) 6 Yrs.	If Under Months	1 Year If Under Days Hours	Min.	8. Date of Birth (Month, Day, 1 March	9. Birt 25 1921	hplace (State or Foreign untry) Maryland
	Director	-	Usual Residence of Decedent	A 0	0				Haren	23,1721	Maryrand
	yland how		10a. State 10b. County		City, Town or Lo						10d. Inside City Limits
:	Ba-1 el	ctor	MD Baltim	ore	Middl	e Kı	ver 				1 ☐ Yes 2√∑No
:	or 28	Director	10e. Street and Number	D 3		10f. Zip			10	g. Citizen of What Co	ountry?
	s 23e		3802 Chestnut	KOaa 12. Was Decedent Ever in	n U.S. 13	Was Dece	21220	igin? (Spec	cify Yes or No-	USA 14. Race - Ame	rican Indian,
	r tter de	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 √ Yes 2 No If Yes, Give			dent of Hispanic Ori city Cuban, Mexican		lican, etc.)	Black, Whit	e, etc.
215-0036	n 72 hours after death with the Maryland "naturel", or items 23a or 28a-f ehow kidical Examiner must be mulified at	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes				Specify:Whi	.te
ה ה	72 ho natur	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usu kind of wo	al Occupation rk done during mos se retired)	t of workin	g 11	6b. Kind of Business/	Industry
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N.	Hygie Hygie ther	e Co	12th 17. Father's Name (First, Middle, Last)					er's Name	(First, Middle, Ma		
/iand	id be ental ked c	To B	Stanley Sersen				Vi	ictoi	ria Mys	zkiewicz	:
a Z	should and Men s marke umatic	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Addres	(Street and Number	er or Rural	Route Number,	City or Town, State, 2	Zip Code)
Σ	and 2 saith a n 27 i		Raymond Sersen								MD 21157
Baltimore,	Pages 1 annent of Healint: If Item irry or other	H	20a. Method of Disposition **Burial 2 Cremation 3	- 44	b. Place of Dispo	matory or a	ther place)			Oc. Location - City or	
Ē	t. Pag tmen tant: tury		4 □ Donation 5 □ Other (Specify	,	t.Stan					Baltimor	
g	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Licens	see /			nd Address of Facilit	300		Ave. Bal	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the d	leath. Do not en	ter the mo	e of dying, such as	cardiac or	respiratory arres	of Essex	Approximate
١,	Physician		Immediate Cause (Final	one cause on each line.	<						Interval Between Onset and Death 24 June
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ı	Examiner		Sequentially list conditions.	b. Aspirad	10n	Pro	morria				1-3 days
	sit 9d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):	Al-	imonia Ehemov	1		J	1-3 days
	be executed icien and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a con		/) / .					10 year.
		cai		d							
9	eath certificate attending phys I for use as the	Aedi	18 55 111 5								
Вох	ith cer tendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3	⊒Ectopic p				23d. Date of de Month	livery Day Year
o.	the al	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐ Unknown	of death 5[Other (s	oecify)				
0.	res that the de signed by the a I be detached f		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	ınderlying	cause given in Part I	l,	23e. Did toba	acco use contribute to	the cause of death?
Division of Vital Records,	uires n sign	Completed by	COPD						1 ☐ Yes	2 □ No 3 □ P	robably 4 Sunknown
Ö	law require as been sig 2 should t	oiete							24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
E.	The la	mo:							perform	ed? death?	2 No
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<u></u>	Physic this c alding	၉	TU Yes 220No		2 ER/Outpatie				ne 5 Resider	nce 6 Other (Spe	cify)
no	ding f h. After funer	tlon	27. Manner of Death 1 S Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	r) 28b. Time o	м	28c. Injury at Work? 1 ☐ Yes 2 ☐	1	ou. Describe not	w injury occurred	
<u>isi</u>	Attending Physicien: The law requires that the death certificate or death. scoot: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	fica	3 Suicide 6 Could not be	28e. Place of Injury - /	At home, farm, st	reet, facto				eet and Number or R	ural Route Number,
Ħ	s efter	Certification;	4 Homicide	building, etc. (Sp	өспу)				City or Town,	3(4(4)	
	To the Hospital or Attending Physicien: The knithin 24 hours eiter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director. page?	edicai		ysician: To the best of my niner: On the basis of exar and manner stated.							
	ro the	Mec	29b. Signature and (the of certifier	and the state of t		29	c. License number		29	d. Date signed (Mon	h, Pey, Year)
			> You				P617	31		12/19	106
	Q		30. Name and address of person who		- 11			, _	- 0	01	2122
	U		Regina Gan-Card 31. Date filed (Month, Day, Year)	en MD 9105	Frankli	1 500	ene Dry S	40 3	12, Bal	to, MD	21237
	Sta Regist		DFC 2 6 20	400	H lo	90/8					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22, **Physician** Month Betty May Schmidt December 2006 3:25 РΜ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 517 B Middle River Rd. Middle River If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🖫 F 213 28 8967 76 Yrs. Director Feb. 9, 1930 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at 1 Yes 2 No Maryland Baltimore Middle River Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or idical Examiner must be 517 B Middle River Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than the Homemaker Own Home 11 traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental F marked Jessie C. Boblits Jessie Carey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar important: If item 27 is n 517 B Middle River Rd. Baltimore, Maryland 21220 Patricia M. Osborne (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/27/2006 Gardens Of Faith Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. W 1407 Old Eastern Avenue Essex, Maryland 21221 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myocanus /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes P.O. 9☐Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 | Yes 2 | No 3 | Probably ♠ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate or Vital 1☐ Yes 2X No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5X Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? al or Attending Fafter death. 28d. Describe how injury occurred Certification; Division 5 Pending investigation Injury 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar (Check only one)

29b. Signature and title of certifier

TOR 31. Date filed (Month, Day,

30. Name and address of person who completed caus-

DEC 2 6

Year)

2006

egistrar's Signature

29d. Date signed (Month. Day, Year)

			for State Registrar	State of W	ai yiai iu /		tificate of		ı ivi c ii		Reg. No	2 U	06	4104
Ý	Physici	an	1. Decedent's Name (First, Middle, La					-		Date of De Month	Da	у	Year	3. Time of Death
digit .	/Medic	al	Marian F. Shoem 4a. Facility Name (If not institution, given				4b. City, Town, o	r Location of De		EC	2	County of	t Death	2:41 PM
F	Examin	er		HOSPITAL			BALT		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			N/A	Douth	
零	Funeral		Social Security Number 6.	Sex 7. Ag	ge (In yrs. last		If Under 1 Year Months Days	If Under 24 h	rs. 8. I	Date of Bir Month, Da	th v, Year,		9. Birthp	place (State or Foreigntry)
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	/land ow at		10a, State 10b. County	-	10c. City, To	own or Lo	cation						1	0d. Inside City Limits
	a-f sh	ctor	Maryland Balti	more	На	leth	orpe							1 ☐ Yes 2 ☐ X
	iff the	Dire	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of W	hat Cour	ntry?
	s 23a	eral	4102 Oak Rd.	12. Was Decedent	Systin II S	10.5	21227		(Cassify)	V N-		SA 14 Page	Amorio	an Indian,
036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	?		Was Decedent of H If Yes, specify Cuba I□Yes 2XNo	an, Mexican, Pu	ierto Rica	in, etc.)	,-		, White,	
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<u>la</u>	ould be Mental arked c	To B	William Ebberts					Evelyr	Goo	nan				
, Maryland 21215-0036	nd 2 alth a 27 is r trau		19a. Informant's Name/Relationship Cheryl Shoemaker	(Type. Print) / daughte	er		ng Address <i>(Street</i>)2 Oak Rd			e, M		or Town, S 21227		Code)
Baltimore,	jes 1 a of Hea if Item or othe		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 [☐Removal from State	20b. Place ceme	e of Dispo etery, crei	sition (Name of natory or other plac	ce)	Date		20c. L	ocation - C	City or To	own, State
Ē	permit. Pages Department of Important: If the any injury or o	١,	4 ☐ Donation 5 ☐ Other (Special	ify)	West	Aru	ndel Crem	atory 1	2-26	-200	6 Od	entor	, M)
Ba	permit. Departm Importa any inju		21. Signature of Funeral Service Lice				Name and Addre	7	Home	of I	ans	downe	2	
	*		23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that cause one cause on each li	d the death. E	Do not ent	2719 Hamm er the mode of dyir	onds Fe	diac or re	Rd . spiratory a	Lan	sdowr	ie, N	pproxima e Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		C PAN a consequen	- Contract -	TEMO	RRHA	5 E				-	3 Weeks
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22	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Myc C4 Due to (or as	a consequen		11/4/11-	CITON	J				-	D11-17
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	rtificat ng phy as th	Medi	IE ECMALC.											
Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3[Ectopic pregnancy Other (specify)	<i>y</i>				23d. Date Mon		ery Day Year
ds, P	uires that signed b Id be deta	Completed by Ph	Part II. Other significant conditions PULMONAILU E			g in the u	nderlying cause giv	en in Part I.		23e. Did t				ne cause of death? pably 4 □Unknown
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<u>ta</u>	cian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Place of I	Death (Cl		-/- -			
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ono	dlng h. After funer	tion:	27. Manner of Death 1 ★ Natural 5 Pending 2 Accident investigation	(Month, Da		Injury	Wor	yat k? Yes 2∐No	200.	Describe	now inju	iry occurre	a	
Division or Vital	l or Atten after deat Director:	Certification:	3 Suicide 6 Could not to determined	28e. Place of in	jury - At home tc. <i>(Specify)</i>	, farm, str	eet, factory, office	85		Location (: City or To			r or Rura	al Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying P	hysician: To the best miner: On the basis and manner st	of my knowle- of examination tated.	dge, deat and/or in	h occurred at the til vestigation, in my o	me, date and pl opinion, death o	ace, and ccurred a	due to the	cause(s	s) and mar ad place, a	ner as s	tated. the cause(s)
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SHOEMAKER, MARIAN

06-09810 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Eric Smith State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day December 24, 2006 Medical Examiner 0430 hrs C 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Mercy Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director Country) 1 XM 2 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No or items 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Yes 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 3 Widowed Specify ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical of Health and Mental Hygiene If item 27 is marked other than Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname Kenin Annette 19a. Informant's Name/Re(ationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mothe 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) Cremation 3 Removal from State Burial -200 Cemeter undalk Donation 5 Other Specify 21. Sign - e of Fune - l Servi - Lic mplications that caused the death. Do not enter the mo of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** folium. List only one cause on each line Between Onset and /Medical Death Acute rancreatitis complicated by diabetic ketoacidodis Imm te Cause (Final disease ⊊xaminer or condition resulting in death) Due to (or as a consequence of): Alcohol abuse Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED **AMENDED** ending physician use as the burial #23a-b.27. 1/19/07 TT Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Month Day Year Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of perform<u>ed?</u> death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 / Inpatient 2 DOA Other₄ Nursing Home 5 ER/Outpatient 3 Residence 6 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Manner of Death 28d Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No d in by the f Pending Accident 2Be. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City Suicide Could not be within 24 hours a To the Funeral I 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifie 29c. License numbe 29d Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

OCMF 2006

30. Name and address of person who completed caus of death (Item 23a)

2006

Zabiullah Ali, M.D.

31. Date filed (Month, Cay, Year) DEC 2 6

Assistant Medical Examiner

egistrar's Signat

O.C.M.E

111 Penn Street, Baltimore, MD 21201

December 24, 2006

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Norman Leonard SCHENKER December 23, 2006 9:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 26, 1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F Mary Land 79 Director 212-24-9893 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location r than "naturel", or iteme 23a or 28e-f ehow the Madical Examinar must be notified at 1 Yes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 6121 Montrose Road United States e filed within 72 hours after death in Hygiene. other than "naturet", or Iteme 23: Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify þ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Pharmacist Pharmacy permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth eny lighty or other traumatic event ORE: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benjamin Schenker Ida Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 Esther Schenker, Daughter 620 Kenbrook Drive, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lebanon Cemetery 12/26/06 Adelphi, MD 21. Signature of Juneral Gervice Lie Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PARKINSONS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Be Completed by Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2. No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2☑ No Certification: To 27. Manner₁of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 🗌 Pending after death. investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061096 gusha 2 30. Name and ad 17-ss of person who completed cause of death (Item 23a) (Type, Print) MONTROSE ROAP ROCKVILLE, MOLOSS, GOLLAPALL, 6171 32. Registrar's Signature 31. Date tiled (Month, Day, Year) State DEC 2 6 2006 Registrar

Physician /Medical Examiner burial-trar

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attending physician for use as the buria

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signed by t d be detach

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certificate Physician:

director

After this funeral dir

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Certification:

Medical

Box 68760,

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Division or Vital Records,

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permit. Pages 1 and 2 to Department of Health ar Important: If item 27 is any Injury or other trau

Saltimore, Maryland 21215-0036

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Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. perform 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

TODD KOLB, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, MARYLAND 21287

29d. Date signed (Month, Day, Year)

DECEMBER 20 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE

State Registrar

31. Date filed (Month, Day, Year)

Fodel M. Loll

29b. Signature and title of certifier



MEDICAL DOCTOR

29c. License number

RES-000

Decident Name (Free March, Late) Control of the		•	For State Registrar	State of	maryıar	nd / Depa <i>Cei</i>		it of He te of D		з ме		ene g. No.	006	410
Packet P			1. Decedent's Name (First, Middle, La	ast)						2	Date of Deat	h		
Mont Care—Bethesda Rethesda Rethes	/Medic	al .			oer)		4b. City,	Town, or L	ocation of De			20,	2006	2:0
2. Sectal Security Numbers 6. Sear 100 Cent 100 Feet 100	. Autiliii	Ψ'					Ro	thecd	2			Mc	n t cor	no ru
212-25-5522 Dec. 77, 1937 Chile	ineral				Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under 24 H		Date of Birth			
Maryland Montgomery Bethesda 10/126 Code Maryland Montgomery Bethesda 10/126 Code Maryland Montgomery 10/126 Code Maryland Mo				1 <u>M</u> M 2□F	6	9 Yrs.	Months	Days	Hours M				Ch:	
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06-09529 Donald Martin To	oom	Please Type or Print in Black Index State of Maryland / Depart	lelible Ink. Ensure All Copic Iment of Health and Mental H		ible.	
	1	- For State Certification	ficate of Death		1 No. 200	3/ Time of Death 5
Physicia Medical Exami	201/	1. Decedent's Name (First, Middle,Last) Donald Martin Toomey			Dav Year	1008 hrs
		4a. Facility Name (if not institution, give street and number) 1111 West Hamburg Street	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 212-60-6044 1X M 2 F 53	t birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min Yrs.		(MM/DD/YYYY 9 Birt Foreig 4, 1953 Co.	
iow any		Tou. State	own or Location			10d. Inside City Limits 1 X Yes 2 No
he Marylan n or 28a-f st	ōI	10e Street and Number 1111 West Hamburg Street	10f. Zip Code 21230	109	g. Citizen of What Cour USA	itry?
Baltimore, MD 21215-0036 permit Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Xi Divorced or Posters: 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No 72-78	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc. Specify Wh	can Indian, Black,
2 hours a "natura I Exami		15. Decedent's Education (Specify only highest grade completed) 1 Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		16b. Kind of Business/l	ndustry
DO36 within 7 iene. ier than	ompleted	12	Sheet Metal	e (First, Middle, M	Coast Gua	rd
215-(pe filed val Hygintal Hygintal Hygint, the	Be C	17. Father's Name (First, Middle, Last) Matthew J. Toomey	Elizal	oeth Eva	Till	
D 21 should I and Mer 7 is man	입	19a. Informant's Name/Relationship (Type, Print) David Toomey, brother	19b. Mailing Address (Street and Number or 9 Raylene Court G.			
re, M and 2 Health fitem 2 er traun		20a Method of Disposition 20b. Pla	ace of Disposition (Name of cemetery,	Date	20c. Location - City or	
Limol Pages ment of tant: If	1	4 Donation 5 Other Specify:				e, Maryland
Balt permit Depart Impor	À	21 Signature of Funeral Service U. Insee 23a. Part I. Enter the disease or complications that caused the death.	22. Name and Address of Facility Ambrose Funeral Ho	ome, Inc	· Arbutus MD	21227
Physician /Medical Sxaminer	caminer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to triminating cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Bue to (or as a consequence of): Due to (or as a consequence of):	ation (both methadone and m			Between Onset and Death
h.g. e executed cian and rial - transit		X UNPENDED #23a.PII.2	27,28a-f,perME, g863, 1/2/0	7 TT		
Division of Vital Records, P.O. Box 68760, forthe Hospital or Attending Physician: The law requires that the death certificate be forthe Alborita for each forther. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buris	Physician/Medical	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnat 1 Live birth 4 Pregnant at time of deat 9 Unknown	ancy 2 Fetal death 3 Ectopic pregn		23d Date of delivery Month	Day Year
P.O. E es that the cigned by the detached		Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I		bacco use contribute to	
of Vital Records, P.O. B ng Physician: The law requires that the de ther this certificate has been signed by the meral director, page 2 should be detached it	Completed by	Bone cancer		24a. Was a autops perform	med? prior to death?	topsy findings available completion of cause of
tal Reco	Be C	25. Was case referred to medical examiner? [Hospital: 1 Inpution 2 F	26 Place of Death (Check		Residence 6 ✓ Other	Scope
n of Viv ing Physic After this	₽	1 Yes 2 No	ER/Outpatient 3 DOA Outlet Nursi 28b. Time of Injury 28c. Injury at Work?		low injury occurred	. ocene
Division of the Hospital or Attendin within 24 layers after death tro the Funeral Director: A completely filled in by the fun	Certification:	Natural 5 Pending Investigation 28e. Place of Injury - At hor determined (Specify) Police	Fnd 10:00 am Yes 2 X No me, farm, street, factory, office building, etc.	unknown 28f. Location (S or Town, St Baltimore	treet and Number or Rutate) 1111 W. Ha	iral Route Number, City
Fo the Hospit Within 24 hod completely fill		29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge	e, death occurred at the time, date and place, an	d due to the cause	e(s) and manner as stat	ed. e cause(s)
To the Ho within 24 J	Medical	one) 2 Medical Examiner: On the basis of examination and and manner stated 29b. Signature and title of certifier	29c. License number O.C.M.E.	at the time, date t	29d Date signed (Mo	nth, Day, Year)
		30. Name and address of person who completed cause of death (Item 2	23a)	11		
9	State	22 Majetrarie Signatur	11 Penn Street, Baltimore, MD 2120			
Penis		DEO 6 1 TOOL				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dey Yeer Month **Physician** 9:10pm Jurina P. Thomas December 21, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Md 220-12-8166 80 Director 6-8-1926 Usual Residence of Decedent deeth with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "naturel", or iteme 23a or 28a-f ehow edical Examiner must be notified at 1 Ty Yes 2 □ No Md N/A Balto Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2710 Baker Street 21216 US Funeral Α 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiane. and I fitem 27 is marked other than "naturel", or item I'll item 27 is marked other than "naturel", or litem I walling Examinary or other traumatic event, the Medical Examination. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: þ Black 3 XWidowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedenf's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Maryland State Police College (1-4or 5+) 8th grade N/A Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Hyman Mary Parker ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Norwood Daughter 8105 Carlson Lane Balto, Md 212144
Date of Disposition /Name of Date Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Druid Ridge Cemetery 12-26-2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md 22. Name and Address of Facility March F/H 21. Signature of Funeral Service Licensee West Lrome 4300 Wabash Avenue A. Thompson Balto, Md 21215 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 year **Physician** disease or condition resulting in death) Congostive
Due to (or to a consequence of): Heart /Medical Examiner Hortic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasf Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnanf af time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute fo the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No been s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? 2 No 2 No 1□ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3□ DOA After this c 27. Manner of Death 28a. Dafe of Injury (Month, Day Year) 28b. Time of 28c. Injury af Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Af home, farm, street, facfory, office building, etc. (Specify) filled in by 4 | Homicide hours after within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number CARBENTWACHENER FIM D0063176 December 21,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland Baltimore Muchinemers N MB 32 Registrar's Signature Chiengenwa
31. Date filed (Mortin Day, Year Gossell 2006 State Registrar

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			State of Maryland / Department of Health and M State Certificate of Death	-	giene Peg. No.	41054
			1. Decedent's Name (First, Middle, Last)	2. Date of De.	ath	3. Time of Death
	Physici		Harry E. Winand	Month 2-	Day Yeer	11:239M
	/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	
			Franklin Square Hospital Center Rosedale		Baltin	oore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bird (Month, Da	th 9.B	rthplace (State or Foreign Country)
	Director		214-16-6640 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1/23/	1921 Pe	nnsylvania
	Ç 📚		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	aryla shov	2				1 Yes 2 No
	Ba-f	Director	Maryland Baltimore Essex			
	ath with the Marylar 23a or 28a-f show ust be nutified at	D	10e. Street and Number 10f. Zip Code		10g. Citizen of What 0	•
		Funeral	320 St. Georges Road 21221 11 Marital Status 12: Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	anifu Van an Na	U. S.	
		'n	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Wh	
36	irs aff	by F	3 □ Never Married 2 □ Married If Yes, Give 1942 1 □ Yes 2 ☒ No Specify: Year or Dates: 1945		Specify:	White
Harry 21215-0036	within 72 hours after ene. then "natural", or ite	ed	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busines	
215	n on	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work life. DO NOT use retired)	ing		
¥ 15	d with	E O	11 Brick Layer		Steel M	i11
Þ	be filed within 72 hutal Hygiene. d other then "netu	Be C		e (First, Middle,	Maiden Sumame)	
lar o	Aenta Aenta rked tlc e	ToE	George Winand Helen	(Un	.known)	
and	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mental Event, the Mental Event, the Mental Event, the Mental Event Even	'	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	al Route Numbe	er, City or Town, State,	Zip Code)
$\mathcal{W}' \cap a \cap d'$ Baltimore, Maryland	permit. Peges 1 and 2 should Department of Health and Men Important: If tem 27 is marke eny Injury or other traumatic once.		Harry Winand (Son) 1210 Vermont Road	Bel A	ir, Mary	land 21014
ore.	of He of He fiter		comptent arematent are other place	Date	20c. Location - City of	r Town, State
₹ E	Peges nent of h int: If it		1 △Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veteran Cemetery	12/28 2066	Garrison	Forest, MD
E E	permit. Departir Importa eny Inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	_		101000, 110
m	90 E 9		Michael C Selhow Sr. Bruzdzinski Funeral 1407 Old Eastern Av	ноте Р enue Е	A Ssex, Marv	land 21221
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac a shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final			Onset and Death
1	/Medical		disease or condition resulting in death) Due to (or as a consequence of):			
	Examiner					
-		je.	Sequentially list conditions, if any, leading to immediate cause. End Underlying Cause (Disease or injury			
1	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events			
V	en ar en ar rial-t	Ä	resulting in death) Last Due to (or as a consequence of):			
8760	ate be shysici the bu	dical	d			
9	rtifica ng ph as th	Jed	IS SERVALE.			
Box	eath certific attending p	an/	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of d	
Ξ.	o death the atte	SICI	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
o.	at the by th	h	9 Unknown			
s,	es tha igned I be det	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute	
pro	w require been sig should b	ed		101	/es 2□No 3□F	Probably 4 Dunknown
သို့	e law r has be je 2 sh	ple		24a. Was autop	an 24b. Were a	utopsy findings available completion of cause of
Division of Vital Records, P.O.	Attanding Physician: The law requires that the death certific r death. • ctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Completed		perfo	rmed? death?	s 2 No
ita	ician: Th certificate rector, pag	BeC	25. Was case referred to medical 26. Place of Death			
>	ysicia iis cert direct	To	examiner? 1 Yes 2 No Hospital: 1 patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Resid	dence 6 Other (Sp	ecify)
٥	ding Ph h. After th funeral	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe I	now injury occurred	
Ö	Attandid death. ctor: Al y the fu	Certification;	2 Accident investigation M 1 Yes 2 No			
.≅	f or Attan efter deatl Director:	tiff(3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tox	Street and Number or F vn, State)	Rural Route Number,
0	ital or rs efte al Dir	Cer				
	Hospitat 14 hours e Funeral i tely filled	Medical	29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	and due to the ed at the time,	cause(s) and manner a date and place, and du	is stated. le to the cause(s)
	To the Hospital or / within 24 hours efter To the Funeral Direction completely filled in D	Med	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	nth. Dav. Year)
	⊢ ≱ ⊢ 8			ŀ		
	16 X1		30. Name and address person who completed cause of do th (Item 23a) (Type, Print) Dr. William hrimsky 9000 Franklin Square		12-12	-06
	1),		30. Name and address person who completed cause of de th (Item 23a) (Type, Print)	Dela	Bolls	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ווווע	- DUITMON	e, MICI C165)
	Registi		31. Date filed (Month, Day, Year) DEC 2 5 2006 32 Registrar's Signature			

			For State Registrar	State of Maryla		ent of Health and ate of Death		21116	41055
K		Ī	Decedent's Name (First, Middle, Last)	i.		13	2. Date of Death		3. Time of Death
	Physic /Medi		CHARLES	17	W	alker	Decembe	2 2 2006	8:30A M
*	Examir	ner	4a. Facility Name (If not institution, give s Baltimore Kehabila	station Exten	ded Care	ity, Town, or Location of De. Backmo	~	4c. County of Death Baltin	More
100	Funeral Director		0120-20 2218	M 2□F 7. Age (In yrs	:. last birthday) If Un Yrs. Mont	der 1 Year If Under 24 Hi hs Days Hours Mi		ar) 9. Birth	place (State or Foreign ntry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside Çity Limits
	Ba-feh	ector	md. N	IA	Bal	timore			1 des 2 des 2 des
	h with ti	al Dire	10e. Street and Number 229 N · Mo	unt St. 1	78t, 101.	Zip Code 2 1223		Citizen of What Cou	ntry?
9	72 hours after death with the Maryland natural', or Items 23a or 28a-f show alsal Examinat must be multied at	Funeral Director	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in I Agned Forces? 1 Nes 2 No	14/	cedent of Hispanic Origin? pecify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White	
21215-0036	"natural", c	ted by	3	ation	16a. Decedent's L	s 2 No Specify:	16b	Specify:	DIACK
1215	within ene. then *	Completed	(Specify only highest grade	College (1-4or 5+)	(Give kind of life. DO NO	work done during most of w Tuse retired)	orking	Constr	yctron
	be filed tal Hygi d other svent,	Be Co	17. Father's Name (First, Middle, Last)	~(//	Constr		ame (First, Middle, Maid	len Sumame)	
Maryland		To	19a. Informant's Name/Relationship (Typ	Walke		Kath	verine.	Davis	
Ma	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Anna Faster -	daughter	405 K	ess (Street and Number or F	FT Perri. B	y or Town, State, Zi	1
Baltimore,	0 0 = =		20a. Method of Disposition 1	O 20b.	Place of Disposition (incometery, crematory)	Name of prother place)	Date 20c.	Location - City or T	own, State
altin	프 는 문 근		4 □Donation 6 □Other (Specify) 21. Signature 1 uneral Service kicense	1	arnson 22. Name	and Address of Facility	129106 00	HILTON	nills mo
0	Depa Impo sny ii		Spy / Min		Gan	y P. march F			md. 21229
1	Division		23a. Party. Phor the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	cations that caused the dea e cause on each line.		A	ac or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse		ixed			o months
	Examiner	er	Sequentially list conditions. b.	Due to (or as a consec	quence of):				
V	acuted ind transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
8760,	ficate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consec	quence of);				
9	artificating phy	Medic	IF FEMALE:						
.O. Box	the death certific y the attending p	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ic. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of of 9 Unknown	al death 3 Ectopic	pregnancy (specify)		23d. Date of delive Month	ery Day Year
Д.	that ed b deta	by Ph	Part II. Other significant conditions cont	ributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobacc	o use contribute to t	ne cause of death?
ords	v require been sig should b				·		1 🗆 Yes	2 No 3 Prot	pably 4 Unknown
Vital Records,	has has	Completed					24a. Was an autopsy performed?	prior to co	psy findings available impletion of cause of
ita	ilcien: Th certificate rector, pag	Be Co	25. Was case referred to medical			26. Place of De	1 Yes 2 A	Vo 1 ☐ Yes	2 No
of <	Physicien: r this certific ral director,	유	1 163 2 140		ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 □Other (Specif	y)
ion	ding Afte fune	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	lury occurred	
Division	in the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fact fy)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rura ate)	I Route Number,
	To the Hospital or within 24 hours afte within 24 hours afte To the Funerel Direct Completely filled in its completely fi	Medical C		br. On the basis of examine	owledge, death occurrention and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as s	tated.
	Fo the within 2 Fo the complex	Med	29b. Signature and title of certifier	and manner stated.		29c. License number		Date signed (Month,	
1			> Very Colon	m /w/		D000325		-	
	Jx,		30 Name and address of person who con PERRY COLV (N	Inpleted cause of death (Iter	North (D000325 Treenc St	reet Bo	elfimo	re Mi)
	Sta Registr	_	31. Date filed (Month, Day, Year) DEC 2. 6. 2006	32 Hegistrar's Signa		,			

06-09548 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Christopher Whitfield State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First_Middle Last) Physician/ 0140 hrs December 15, 2006 **Medical Examiner** risto pher 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number Baltimore University Hospital If Under 1 Year If Under 24Hrs. 8. Date of 8irth(MM/DD/YYYY) 9. 8irthplace (State or 5. Social Security Number in 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Director Country) 1 X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County Yes 2 No 28a-f show or items 23a or 28a-f sho must be notified at once. permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10g. Citizen of What Country 20 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 4 Divorced If Yes, Give Year 1 Yes 2 No specify 3 Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Kind of Business/Industry Completed Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Home Improven 18 Mother's Name (First, Middle, Maiden Surname 17 Father's Name (First, Middle, Last Mar Edward 0 19b. Mailing Address (Street and Number or Rural Loute Number, City or Town, State, Zip Code) 5 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State em Donation 5 Other Specify: 21. Signature of Funeral Service Licenses Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and tran. Physician/Medical UNPENDED AMENDED attending physician for use as the burial. #19a, perFH Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Speafy) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 V No 3 Probably 4 Unknown After this certificate has been a 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? . death? ✓ Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Fo the Hospital or Attending Physician: Be Other₄ Hospital: 1 🗸 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work' 28d Describe how injury occurred 27. Manner of Death Certification: Dec 15, 2006 Subject shot Natural 5 Pending 1 Yes 2 ✔ No To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 3813 S. Hanover St., Baltimore, Md (Specify) Sidewalk 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

27

Name and address of person who completed cause of death (Item 23a)
 Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DEC 2 6 2006

ORÎGINAL

O.C.M.E.

December 15, 2006

Registrar

			For State Registrar	State of Maryla		irtment of F tificate of		R	eg. No.	41057
ı	Physicia		1. Decedent's Name (First, Middle, Last) Victoria	Moodv	Addis			2. Date of Dear Month December	Day Year	3. Time of Death
Ž-	/Medic Examin		4a. Facility Name (If not institution, give st 1728 Biggs Highw 5. Social Security Number 6. Sex	ay 7. Age (In yrs	s. last birthday) Yrs.		g Sun If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, SEPT 26,	4c. County of Death Cecil Year) 9. Birth Cou	place (State or Foreign
	Director Mou		213-20-8576 Usual Residence of Decedent 10a. State 10b. County	A 81	City, Town or Lo	cation		SEPI 20,		10d. Inside City Limits
;	with the Mar a or 28a-f el be notified	Director	Maryland Cecil 10e. Street and Number		E1kton	10f. Zip Code 21921		1	Og. Citizen of What Cou	
36	be filed within 72 nours after death with the Maryland ital Hygiene. Ital Hygiene. do other than "naturel", or iteme 23s or 28s-f show event, the Madical Exeminar must be notified at	by Funerai	53 Hunt Valley Dri 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ican fndian,
21215-0036	within 72 hour ne. hen "neturel e Wedicel E	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work d)	ing	16b. Kind of Business/li	
Maryland 2	9 7 5 S	To Be Co	12 17. Father's Name (First, Middle, Last) William John Moody		1, 1,	orar besi	18. Mother's Name			
	ages 1 and 2 should but of Health and Ment I: If Item 27 Is marked y or other treumatic e		19a. Informant's Name/Relationship (Type Margaret W. Lamm/N	iece	53 Hı	int Valle	y Drive,	Elkton,	r, City or Town, State, Zi Maryland 2 20c. Location - City or 1	1921
altimore,	permit. Pages I Department of H Important: If ite any injury or ot once.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signarure of Funeral Service License	I I	Elkton (sition (Name of natory or other pla Cemetery 2. Name and Addre	20. 2	ber 006	Elkton, Ma	ryland
Ba Ba	Department of the partment of		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the de					A. cton, Maryla	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to annuadiate	Due to (or as a cons	equence of):	sease				Onset and Death
28, 09, 89	eath certificate be executed attending physicien and for use as the burial-transit	edicai Examiner	if any, heading to minisdials cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons						
P.O. Box 6	the death certifi y the attending ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 23€No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 For 4 Pregnant at time o 9 Unknown	etal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у		23d. Date of deli Month	very Day Year
ords, P	w requires that the de been signed by the a should be detached f	Ď	Part II. Other significent conditions con	tributing to death but not r	esulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
al Reco	ysicien: The law r is certificate hes be director, page 2 sh	Completed							sy prior to death? 2.23 No 1 ☐ Yes	topsy findings available completion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ation: To Be	25. Was case referred to medical examiner? 1 Yes	ospital: 1 □ Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju	ry at	ome 5□Resid	ence 6 🛣 Other (Specow injury occurred	ssisted W)Living
Divis	To the Hospital or Attending Phy within 24 hours etter death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Pface of Injury · Albuilding, etc. (Spe	ecify)		agger a week	City or Tow	·	
	Fo the Hosi within 24 ho Fo the Fund completely f	Medical	29a. Certifier (Check only one) Certifying Phys (Check only one)	ician: To the best of my ker: On the basis of exam and manner stated.	ination and/or in	vestigation, in my	opinion, death occur	red at the time, o	date and place, and due	to the cause(s)
)	Jr		30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type	000	Aberdeon	, M O >	12/18/06	
	Sta Regist		frashant Shukla 31. Date filed (Month, Day, Year) NFC 2 6 201	32 Megistrar's Sig	orke St.	#44 /	Therdeon	A.C.())	(00)	

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			1 For State	State of Maryland				-	- 7		1.1058
			Registrar		Cer	tificate of	Death	2. Date of De	Reg. No.	.000	3, Time of Death
	Physicia	an	Decedent's Name (First, Middle, Land)	N. A.				Month	Day	Year	· · · ·
	/Medic	al	4a. Fecility Name (If not institution, gi	y ASLAM		4h Cihi Town o	or Location of Death	Dec	05	کری ا County of Death	
	Examin	er		` (co'tel			MA	40.0	بادك	1
_	Funeral		1000	Sex 7. Age (In yrs. In		If Under 1 Year	If Under 24 Hrs.		th	9. Birth	place (State or Foreign
	Funeral Director		None	1∭M 2□F	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 12/3/2	006	Mar	yland
	2		Usual Residence of Decedent	140-00							10d, Inside City Limits
	anylar show	<u></u>	10a. State 10b. County	10c. City	, Town or Lo	cation					1 Yes 2 No
	Sa-f	Director	Maryland Howard	Jes	seup	104 7:- 0-4-			10a Citia	en of What Cou	
	with t	吉	10e. Street and Number			10f. Zip Code	70/				
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral	7904 Red Rose Wa	12. Was Decedent Ever in U.S	S. 13. V		/ ソ4 Hispanic Origin? (Spean, Mexican, Puert	pecify Yes or No		ed Stat 4. Race - Amer	ican Indian,
0	be filed within 72 hours after death with the Marylan Hygiene. do other than "natural", or Itams 23a or 28a-f show event, the Marylan Examination must be notified at	by Fun	1 Never Mamed 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		Yes, specify Cub □ Yes 210 No		o Rican, etc.)		Black, White Specify: A.c.	, etc. ian
2-003p	hours tural		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a Deced	lent's Usual Occup	nation		16b Kin	d of Business/li	
0	in 72	Completed	(Specify only highest g	rade completed)	(Give	kind of work done	during most of work	rking	100.10	0 0 003 1103 30 11	iodaliy
7	the second	duo	Elementary/Secondary (0-12) None	College (1-4or 5+)	Non	e			No	one	
0	e filed within at Hygiene. Other than vent, the We	a	17. Father's Name (First, Middle, Las	it)			18. Mother's Nam	ne (First, Middle	, Maiden S	Sumame)	
/and	should be nd Mental marked o imatic eve	To B	Asim Mohammed As	lam			Sughran	Asim Pa	rvee	n	
Mary	and h	'	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street	t and Number or Ru	ral Route Numb	er. City or	Town, State, Zi	ip Code)
Σ.	and and a saith n 27 in 27 in er tre		Asim Mohammed As		A comment of the comm		Way, Je			794	
9	permit. Pages 1 and 2 should be Department of Heath and Ments Important: If Item 271s merked any injury or other traumatic or Once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State Mar	lace of Dispo: emetery, cren	sition (Name of natory or other pla National	ce)	Date	20c. Loc	cation - City or T	own, State
	Fant:		* 4 ☐ Donation 5 ☐ Other (Spec	eity) Mem	orial	Park	1 12/0	06/2006	Lau	rel, Ma	ryland
Baitimore,	bermit Depar mpor mpor my in		21. Signature of Funeral Service Lie		22 Th	. Name and Addre ibadeau	Mortuary Ave., LL,	Service	, P.	Α.	
	uu z e u		22a Party Egypta disease or ear	M00956	193	33 Gist A	roe. LL.	Silver	Spri	ng. MD	20910 Approximate
			23a. Park Enter he disease, or col shock, or heart failure. List on! Immediate Cause (Final					A	11031,		Interval Between Onset and Death
	'hysician /Medical		disease or condition resulting in death)	a. Pytye. Due to (or as a consequ	me	rem	iatori				she birt
	Examiner			Due to (or as a consequence)	erice or).	il was	How	002/2/	ncat.	0	Lez his
	Sign of	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	uence of):	V CO (0 V		1410	-City		7
	cuted	Examiner	trial initiated events	C.							
ĵ	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
8/60	9 % 0	lical		d							
χ Ω	entific ding p	Mec	IF FEMALE:	23c. If yes, outcome of pregnal	201						
X P P	requires that the death certifica ween signed by the attending ph hould be detached for use as th	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal	death 3	Ectopic pregnanc Other (specify)	у		2.	3d. Date of deli- Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	Jan. 3_	Cities (Speeny)					
7	that led by deta	y P	Part II. Other significant conditions	contributing to death but not resu	ulting in the ur	nderlying cause gr	ven in Part I.	23e. Did 1	obacco us	se contribute to	the cause of death?
g	n sign	D	Statis	epilest C	25_			1 🗆	Yes 2]No 3□Pro	bably 4 Unknown
Hecords	w req	iete	,					24a. Was	an	24b. Were auf	opsy findings available
	The law ite has b	m o						auto perfo	ormed?	death?	ompletion of cause of
VIII	(D) 1-2	a)	25. Was case referred to medical				26. Place of Dea			10103	20110
≥	Physician: this certifica ral director, j	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐Inpatient 2 ☐	ER/Outpatien	t 3 DOA Ott	her: 4 Nursing H	lome 5 Resi	dence 6	□Other (Spec	ufy)
10 0	ng Ph ter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		iry at ork?	28d. Describe	how injury	occurred	
0	endii eath. or: A the fu	catie	2 ☐ Accident investigati	bo]Yes 2 □No				
DIVISION	If or Attending Patter death. Director: After the in by the funera	Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (City or To	Street and wn, State)	l Number or Rui	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C		Physician: To the best of my know aminer: On the basis of examinat and manner stated.							
	To th within To th	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date	signed (Month	, Day, Year)
			M. 10.20	see ms		-	00461	99	DI	el o	5 200%
			30. Name and address of person wh	o completed cause of death (Item	23а) (Туре,	Print)					3 3 - 0
			M 1530	N TADES	SE	MS					
	Sta	ate	31. Date filed (Month, Day, Year)	32. Régistrar's Signa	ture	racks 1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Lionel Kervin Anderson	n
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2	U	U	U	1-}		0	J	

			I- For State Registrar	•	Certific	cate of Dea	<i>ith</i>		Re	g. No.	
Med	Physicia lical Exami	an/	Decedent's Name (First, Mide LIONEL	dle,Last) KERVIN	ANDERS	ON			2. Date of Death Month November		3. Time of Death 0135 hrs
(4a. Facility Name (if not institute 5617 Prescott Court		r)		Town, or Lo	cation of Death		4c. County of I	
	Funeral Director		5. Social Security Number 578–90–3227	6. Sex 7. A	ge (In yrs. last bi		nder 1 Year	If Under 24Hrs Hours Min.	8. Date of Birti	13,1960	9 Birthplace (State or Foreign WASHINGTON Country) DC
	>1		Usual Residence of Decedent		140° 0'+ T-				<u> </u>		10d Inside City Limits
	Maryland 28a-f show any 1 at once.			CE GEORGES	CAPIT	OL HEIGH	TS				1 X Yes 2 No
	ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 5617 PRESCOTT	COURT			20743		10	g. Citizen of What USA	t Country?
	fter death w ", or items	by Funeral		Married 12. Was Deceder Armed Force: 1 Yes ivorced If Yes, Give Year or Dates:		If Yes, spe		Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - A White, 6 Specify: B .	
	5-0036 led within 72 hours at Hygiene. other than "natural he Medical Examin	Completed t	15. Decedent's Education (Sp Elementary/Secondary (0-12 9TH		r 5+)	Decedent's Usus during most of w	vorking life. D			16b. Kind of Busin	
	15-0036 filed within 7 Hygiene. d other than		17. Father's Name (First, Middle LIAT TED LI AN	e, Last) IDERSON				.Mother's Name	FOR	aiden Surname)	
	2121 hould be find Mental is marked	To Be	19a, Informant's Name/Relation	nship (Type, Print)	11	9b. Mailing Addre	ss (Street a	ind Number or F	Rural Route Numi	ber, City or Town,	State, Zip Code)
	e, MD I and 2 sho Health and item 27 is		20a. Method of Disposition		20b. Place	of Disposition (Natory or other place	lame of ceme		Date		MD 20712 City or Town, State
	Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other it injury or other traumatic event, he Med		Burial 2 Crematic Donation 5 Other Calculation of Funeral, Service		olale	LIVET CE	•		/02/2006		GTON, DC FUNERAL HOME
	Balti permit. Departm Imports injury o		Queletta =	Hy So	37					GTON, DC	
w.	Physician Medical		23a. Part I. Enter the disease, of failure. List only one cause	se on each line.		not enter the mod	e of dying, su	ich as cardiec d	or respiretory arre	st, shock, or heart	Approximate Interval Between Onset and Death
4	Examiner		Immediate Cause (Final diseas or condition resulting in death)								
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus		sequence of):						
	ecuted and - transit		(Disease or injury that initiated events resulting in death) Last		sequence of):						
	al al	Medical	UNPENDED	AMENDED		-					
	Box 68760, ne death certificate be the attending physicine for use as the burned	sician/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 Live birth 4 Pregnant	ome of pregnanc	y 2 Fetal dea 5 Other (S		Ectopic pregna	ancy	23d. Date of de Month	elivery Day Year
	O. Bo at the de d by the stached fi	Phy	Part II. Other significant conc	9 Olikilowii	ath but not result	ing in the underlyi	ing cause give	en in Part I.	23e. Did tol	bacco use contribu	ute to the cause of death?
	S, P.	ed by								2 No 3	
	Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it	Completed							24a. Was a autops perform	sy prid med? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
	ital Ficians s certificator,	Be	25. Was case referred to medic examiner?	(Hospital:	tient 2 ER/	Outpatient 3		f Death (Check ther Nursi		Residence 6	Other Scane
	of Villing Phys	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of li FOUND:	njury 28b	. Time of Injury	28c. Injury		•	ow injury occurred	
	Division tall or Attendians after death. al Director: Alled in by the fu	ertification:		vestigation Nov 26, 200	06 01	OUND: 25 hrs farm, street, facto		s 2 V No			or Rural Route Number, City
	Division pital or Attencours after death eral Director: filled in by the	Sertifi	4 Homicide de	ould not be	arking Lot	Tarri, Street, Tack	ory, ornice buil	iding, o.c.		ate) Court, Capitol F	
	To the Hospital within 24 hours To the Funeral completely filled	Medical C		Physician: To the best of xaminer: Dn the basis of each manner state	kamination end/o						
	¥ ½ ½ 8	Me	29b. Signature and title of certi				29c. License r			29d. Date signed	(Month, Day, Year)
0	(2)		30. Name and address of person	on who completed cause o	f death (Item 23a)	U. U. IVI.			NOVERIBEI Z	
K	(2)		Jack Titus MD. De	eputy Chief Medical	Examiner	111 Penn Str	reet, Baltin	nore, MD 2	1201		
	S Regis	tate trar	31. Date filed (Month, Day, Yea	Server 32. Regist	trar's Signeture	le					

		-	1- State of Maryland / Department Certificate Certificate			ene 006	41060
	Physicia		Decedent's Name (First, Middle, Last) ALICE MARIE BRIDDELL		2. Date of Death Month December	17, 2006	3. Time of Death 6:07 A. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, 1	Town, or Location of Death		4c. County of Death	
			0103 00111000011 11000	ion Station Year	8 Date of Birth	Somers	et place (State or Foreign
	Funeral Director		5. Social Security Number 216-14-9804 6. Sex 1 M 2 F 89 Yrs. 7. Age (In yrs. last birthday) If Under Months	Days Hours Min.	8. Date of Birth (Month, Day, NOV - 29,	1917 Mar	yland
	and *	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryla -f sho	tor	Maryland Somerset Marion Sta	tion			1 ☐ Yes 2 🛣 No
	with the 3a or 28a I be noti	Funeral Director	10e. Street and Number 10f. Zip 5169 Cornstack Road	Code 21838	10	g. Citizen of What Co. U . S . A .	untry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to fleatht and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Modical Examinar must be notified at	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No	ent of Hispanic Origin? (Sp ify Cuban, Mexican, Puerto IX No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
21215-0036	filed within 72 ho Hygiene. Ither than "naturi ont, I'm M. olcall	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Broiler Gr	k done during most of work e retired)	ing	6b. Kind of Business/I	ndustry
73	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Tra.M.	To Be Co	17. Father's Name (First, Middle, Last) Charles E. Liller	18. Mother's Nam	e (First, Middle, M.		
lary	2 shou and M is mar			(Street and Number or Rur			
	of Health of Health litem 27 (20a Method of Disposition 20b. Place of Disposition (Nam			Station, M Oc. Location - City or 1	
mor	Pages nent of H int: If ite iry or of	ı	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rehobeth Baptist (/20/06	Rehobeth,	MD
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature Interar Service License Bradsh Robert H. Bradshaw, Jr 306 W.	Address of Facility Naw & Sons Fu Main St C	neral Hor risfield	me , MD 2181	7
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each fine.	of dying, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death
	-nysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. ARGE CELL L Due to (or as a consequence of):	4 NI PHUI	<i>77 71</i>		YEARS_
	cate be executed physician and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate Cause. Finer Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):				
P.O. Box 6876	The law requires that the death certificate bate has been signed by the attending physicage 2 should be detached for use as the bate.	Physician/Medical	d			23d. Date of defi Month	very Day Year
rds, P.	quires that n signed b uld be deta		Part II. Dther significant conditions contributing to death but not resulting in the underlying ca	ause given in Part I.	23e. Did toba	acco use contribute to s 2 PNo 3 □ Pro	the cause of death?
I Records,	The law require ate has been si page 2 should !	Completed by			24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
Vita	Physician: this certificantal director.	Be	25. Was case referred to medical examiner? Hospital:	Other	h (Check only one		
Division of Vital	ling After fune	tion: To	1 Tes 2 No 1 Inpatient 2 EN Outpatient 3 DO	8c. Injury at Work? 1 Yes 2 No	28d. Describe how	nce 6 Other (Spec vinjury occurred	eny)
Divisi	al or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the i	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred and manner stated.				
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c	. License number		d. Date signed (Month	
			7				R 19, 2006
	C		Comment has no 1415 South	74 DIVISION S	Enise B	SALISTS MRU	m021804
	Sta Regist		31. Date filed (Month, Day, Year) DEC 2 6 2006 32 Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Burkholder **Physician** Emma Elizabeth EEMBER 13 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hagerstown Washington Washington County Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Year! Hours Months Days 1 M 2 W 82 18 1924 Maryland 174-20-8956 August Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exa<u>miner must be notified at</u> 1 ☐ Yes 2 No Director MD. Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 U.S.A. 16535 Fairview Rd. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or ites 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛣 No White Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha E. Meyers Abraham H. Martin permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic ev မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8722 North Rabbit Rd. Greencastle, Pa. 17225 Harold R. Burkholder/Son 20b. Place of Disposition (Name of cemetery, crematory or other place Millers Mennonite Church Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State 12/18/06 Leitersburg, Md. 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 21. Signature of Funeral Service Licensee 17225 45 S. Carlisle St. Greencastle, Pa. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): EVORAL **Physician** /Medical Examiner RITCAL AOA Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 3 ☐ Probably 4 ☐Unknown 1 TYes 2**□M**0 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performe 2□No 1 ☐ Yes 1 Yes 2 No certificate ACUTE or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred uneral 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation ours after death. neral Director: A filled in by the fu 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a To the Funeral I completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only and manner stated.

10

To the

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

32 Registrar's Signature

29c. License number

130

SUITE

MOJICAL

29d. Date signed (Month, Day, Year)

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show important; if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Merical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physician

/Medical

Director

Examiner

Funeral

Director

Physician /Medical Examiner

> burial-trar cate has been signed by the attending physician, page 2 should be detached for use as the burial After this certificate has within 24 hours after death.
>
> To the Funeral Director: After this certific completely filled in by the funeral director,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Be Completed by

ra	12712 Found Stone	≥ Road #105			20876		United	States
ne	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Span. Mexican, Puert	pecify Yes or No-	14. Race - Am Black, Wh	
by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		□Yes 2【XNo	Specify:	, , , , , , ,	Specify:	Black
To Be Completed by Funeral	15. Decedent's Edu (Specify only highest grad	ication 1 de completed) 1	16a. Deced (Give F	ent's Usual Occup	ation during most of wor	kina I	. Kind of Business	s/Industry
шb	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done o		9	_	
ပိ	12 17. Father's Name (First, Middle, Last)		ра	y Care Pi			Day Care	2
Be	Leonard Wolcott					ne (First, Middle, Maid	den Surname)	
P						a Russell		
	19a. Informant's Name/Relationship (T) Walter Lee Brown /	1				ral Route Number, Ci.l. $\#105$, $$		Zip Code) n., MD 20876
	20a. Method of Disposition			sition (Name of patory or other place			Location - City or	
3	1 ☐ Burial 2 【XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Metr	opoli remat	tan orv	Dece	aber 6 A1	exandria	, Virginia
	21. Signature of Funeral Service Liegns	ee vue		Name and Addres	20	Vol Funera ersburg, N	al Home, 4D 20877	10 East Deer
	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of							Approximate Interval Between
	Immediate Cause (Final disease or condition	CHRONIC UB	stive	tive Pu	MA Lar AD W	Nicons	0	Onset and Death
	resulting in death)	Due to (or as a consequen	ice of):	100	1	13-63	τ	years
	Out on the last of	b						
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequen	ice off:					<u> </u>
ill.	that initiated events	c.						
Ĕ	resulting in death) Last	Due to (or as a consequen-	ce of):					
cal		d						
led					_			
Ž.	Zob. Was decedent pregnant	23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal de		Estania programana			23d. Date of de	livery
icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of death		Ectopic pregnancy Other (specify)			Month	Day Year
hys	9 ☐ Unknown	9□Unknown						
Ϋ́	Part II. Other significant conditions con	ntributing to death but not resultin	g in the und	derlying cause give	en in Part I.	23e. Did tobaco	o use contribute t	o the cause of death?
edk	Dicheter					1 X Yes	2 □ No 3 □ P	robably 4 □Unknown
Be Completed by Physician/Medical Examiner	(ARDIOMY) 1 At	hy				24a. Was an	24b. Were a	utopsy findings available
E O						autopsy performed	? prior to death?	completion of cause of
Ö	25. Was case referred to medical	'			26 Place of Door	th Check only one)	No 1 Ll Yes	3 2 No
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 I ER/	/Outpatient	3 DOA Othe		ome 5 Residence	6 Dothor (Co.	
<u> </u>	27. Manner of Death	28a. Date of Injury 28	b. Time of	28c. Injun	at	28d. Describe how in	jury occurred	ecny)
텵	1. ■ Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		?? Yes 2 □ No			
<u>i</u>	3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At home	, farm, stre	et, factory, office		28f. Location (Street	and Number or R	ural Route Number,
Sert	4 ☐ Homicide determined	building, etc. (Specify)				City or Town, St	ate)	
Medical Certification: To	(Check only 2 Medical Exami	sician: To the best of my knowled	dge, death	occurred at the timestigation, in my or	ne, date and place, pinion, death occur	and due to the cause	e(s) and manner a	s stated.
led	010)	and manner stated.						
~	29b. Signature and title of certifier	Ball mo		29c. License		29d. I	Date signed (Mon	th, Day, Year)
)08hr 4	DAII MD		D5	3311	Dec	embu	5 2006
	30. Name and address of person who co	empleted cause of death (Item 23)	a) (Type, P	rint)	H	- 1 11	1	
		LIIMB 16220	trede	rick Ku	00 4 21	3 OATher	ibus n	10 20877
te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	b A	rick 2.				-
ar	PF0 - ((2006 Jane 1	- 1	MACL!				

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** рм Elizabeth Marie Barnes-Merson December 3, 2006 7:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Age (In vrs. last birthday **Funeral** 1 □ M 2 □ F Director 218-26-0468 27, 1930 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2√ No Director Maryland Montgomery Wheaton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 shours we man be partment of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be nonce. 12004 Charles Road 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ Z No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: White 3 X Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Specialist Electronics 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emory Johnson Johnson Maude 19a. Informant's Name/Relationship (Type. Print) —Granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pressman Jacquelynne K. 7706 Carter Road, Sykesville, Maryland 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2006 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Addigss of Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Erner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause pleach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner ON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of) Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform Yes 2 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2[**X**No 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending | for use as ed by the a been signed be should be deta has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dire

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar 29a. Certifier

(Check only one)

29b. Signature and ti e of certifier

2006

29c. License number

29d. Date signed (Month, Day, Year)

30 Warne and address of person who completed cause of death (Item 23a) (Type Print) EC 31. Date filed (Month Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar's Signature 32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Amend#29d. PerPhys. 12-7-06cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Recember Physician BURCH BESSY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Doctors Hospital Lanham If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Days Months 1 ☐ M 2 🕱 F 249-96-3127 Director May 28, 1951 South Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ex-miner must be notified at Director 1X Yes 2 □ No MD Prince Georges Lanham 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20706 6204 Seabrook Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 X Widowed 4 ☐ Divorced B1ack Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 years Administrative Assistant IEEE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Nowlin Jannie Ham ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janel Burch/ Daughter 20706 6204 Seabrook Rd. Lanham, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Cemetery 12-9-2006 Brentwood, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th st. N.W. Washington, DC 20011 23a. Part1. Boer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or spiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as it **Examiner** Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to-P.O. Box 68760 Physician/Medical sate has been signed by the attending physi page 2 should be detached for use as the l IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant/conditions contribu iting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 1∐ Yes 2≦ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate ! Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P Certification: After 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral D 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number

40

State Registrar 31. Date filed (Month, Day, Year)

FC 0 7 2006

HOLLAND,

32. Registrar's Signature

6005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of M	larylan	-	artmen rtificate			and M		giene	006	410	165
	Dhuaiai		1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	th Day	Year	3. Time of	Death
	Physicia /Medic		Lloyd Elliott B								Decembe	er 6,	200	6 9:35	A ^M
	Examin	er	4a. Facility Name (If not institution)				Location of			4c. Co	ounty of Dea		
			2214 Gibson Roa 5. Social Security Number		no //n	In me friedbale. I	Fo If Under		Hill If Under		8. Date of Birth		Harf		. 5
	Funeral Director	į	577-42-2685	1 XM 2 F	ge (in yrs.	last birthday) 74 Yrs.	Months	Days	Hours	Min	8. Date of Birth (Month, Day June 12	Year)	9. Bl	rthplace (State of Country) hington	_
			Usual Residence of Decedent			7-1						, 100	- mao		, 2.0.
	rylan ihow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Cit	
	Sa-f s	Director		ford	F	orest								1 🗆 Yes	2 M No
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	s 23g	eral	2214 Gibson Roa	.d 12. Was Decedent	Ever in II	C 121	Was Door		.050	gin? (Sne	noify Vac or No-			States lerican Indian,	
.	ther d	by Funeral	1 ☐ Never Married 2 ☑ Marr	Armed Forces	?		f Yes, spec	ify Cuba	n, Mexican	n, Puerto I	ecify Yes or No- Rican, etc.)	1	Black, Wh		
8	el', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1□Yes 2	No.	Specify:			Sp	pecify: W	hite	
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f show the Madical Exeminer must be notified at	Completed	15. Deceden (Specify only higher	t's Education		16a. Dece	dent's Usua kind of wor	l Occupa	ation furing mos	t of workii	na		of Busines		
2	hen hen	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wor DO NOT us						-	Systems	
'n	filed v Hygie other t		17. Father's Name (First, Middle,	/ 4 / ast)		Elect	ronic	Tec			(First, Middle,			& Develo	pment
and	d Mental in marked o	o Be	Joseph Edward B	ŕ							aomi Koc		mamo,		
Maryland	shoul nd Ma nmarl umatl	٠	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Ruma	l Route Numbe	r, City or T	own, State,	Zip Code)	
	s 1 and 2 should be filed within 72 hours after death with the Marylar of Heelth and Mental Hygiene the Heelth and Mental Hygiene temps 23e or 28e-f show then 27 is marked other than "natural", or Itama 20e or 28e-f show other traumatic avent, the Medical Exeminar must be notified at		Nancy Briscoe /	Wife		2214	Gibso	n Rd	., Fo	orest	Hill,	MD 2	1050		
ore	of Heeli of Heeli filtem 2 r other		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 □Removal from State	20b. F	Place of Dispo semetery, crer	sition (Nan	ne of ther place	e) D	ecem	ber 7,	20c. Loca	tion - City o	r Town, State	
Ĕ	Pag ment snt: I		4 Donation 5 Other (S	pecify)		sthaver				200				, Maryla	nd
Baltimore,	permit. Pages to Depertment of Histoportant: If Ite any injury or ot once.		21. Signature of Furry at Service	Licensee		Re 95	. Name an sthav 01 Ca	en F	s of Facilit unera in Mi	il Se tn. H	ervices, Hwy. Fre	Skko	ot Coo	dy P.A. D 21701	
			23a. Part1. Enter the disease, or shock, or heart failure. List	omplications that cause only one cause on each	d the deat									Approximate Interval Betv	ween
	Physician		Immediate Cause (Final disease or condition	. Metasta	atic 1	Non-Sm	a11 C	e11 :	Lung	Canc	er			Onset and D	
	/Medical Examiner		resulting in death)	Due to (or as	s a conseq	uence of):									
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s al conseo	uetice of:				_					
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ó	icate be executed physicien and s the burial-transit		that initiated events resulting in death) Last	Due to (or as	s a conseq	uence of):									
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89 J	artifica ing pt	Med	IF FEMALE:									-1-			
Вох	death certifica e attending ph d for use as th	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	Ideath 3	Ectopic pr					230	I. Date of de Month		'ear
o.	res that the death certific igned by the attending p be detached for use as	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡ Pregnant a 9⊡ Unknown	at time of d	eath 5L	Other (sp	ecify)							
α.	The law requires that the ste has been signed by the page 2 should be detache	by Ph	Part II. Other significant condition	ens contributing to death	but not res	ulting in the u	nderlying ca	ause give	n in Part I.	,	23e. Did to	bacco use	contribute	to the cause of de	eath?
rds,	quires an sign										1 🔯 Y	es 2 🗆 1	No 3□F	Probably 4 □U	Inknown
Vital Record	aw requir is been si 2 should I	Completed									24a. Was a		4b. Were a	utopsy findings a	available
Ĕ	: The law cete has i	E									autop: perfor	med?	death?	completion of ca s 2 □ No	ause or
/ita	ysician: Th	Be	25. Was case referred to medical examiner?								(Check only or	10)			
6	Physician: this certific ral director,	ဥ	1 ☐ Yes 2⊠No 27. Manner of Death	Hospilal:		ER/Outpatien		A Othe	ar. 4 □ Nu		ne 5⊠Resid			ecify)	
u Q	After	tion	1 ⊠Natural 5 ☐ Pendin	28a. Date of Injugation (Month, Di		28b. Time of Injury	M	8c. Injury Work	at :? ∕es 2∐!		28d. Describe h	ow injury o	ccurred		
Division	Attending r death. sctor: After by the funer	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of In	ijury - At ho	ome, farm, str					28f. Location (S	treet and N	lumber or F	Rura I Route Numb	ber,
á	s ofte	Certification;	4 Homicide	building, e	tc. (Specif	y)	•				City or Tow	n, State)			
	To the Hospital or Attend within 24 hours effor death To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best Examiner: On the basis of and manner s	of examina	wledge, death tion and/or in	occurred a	at the tim in my op	e, date an inion, dea	d place, a th occurre	and due to the c	ause(s) an late and pla	d manner a ace, and du	is stated. le to the cause(s)	
	withir To th	Ň	29b. Signature and title of certile	C/n MD			29c		number	or Li	2	9d. Date s	igned (Mor	nth, Day, Year)	
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	10		30. Name and address of person					77	1	- 1 3	m 01701				
	Sta	to	Elhamy Eskander 31. Date filed (Month, Day, Year)	32 B	west	/th St	reet,	Fre	aerio	ck, P	т 71/0]	•			
	Registr		DEC 0	8 2008 32. Relist	eur.	K A	peri	,							

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1	- Jan -	W	Decedent's Name (First, Middle, Last	st)						te of Death			3. Time of Death
	Physicia /Medic		Pauline M.	Brosna	in					ember	1, 20	06 06	12:30 P ^M
	Examin		4a. Facility Name (If not institution, give	·			4b. City, Town, or	Location of (Death		4c. County		
			12500 Chalford La		/In use in	ast birthday)	Bowie If Under 1 Year	If Under 24	Hrs 9 Do	to of Righ	Princ		
	Funeral Director			m 2 X) F 7. Age	57	Yrs.	Months Days		Min. (Mi	te of Birth onth, Day, Y	(ear) 49	9. Birtini Coul Mary	place (State or Foreign ntry) 1 and
-	10.3		Usual Residence of Decedent						007	01,17		TIGIT)	
	urylan show	_	10a. State 10b. County			, Town or Lo	cation						10d. fnside City Limits
	Be-1 of the	Director	Maryland Howard 10e. Street and Number		Colu	mbia	1.00 70 70 1			1.0			1 X Yes 2 No
	with t		6313 Early Red Co	ourt			10f. Zip Code 21045				g. Citizen of \ SA	vnat Cou	ntry ?
	Jeath The 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S		Vas Decedent of Hi	spanic Origin	? (Specify Ye	es or No-	14. Rac		can Indian,
D	or Itar	Fun	1X Never Married 2 ☐ Married	Armed Forces?	0	į li	Yes, specify Cuba	n, Mexican, F	uerto Rican,	etc.)		k, White,	etc.
2	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			Yes 21 No	Specify:			Specify	Wh	ite
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ם פ	filed Hygi other	0	17. Father's Name (First, Middle, Last)			100011		18. Mother's	Name (First,				
land	Aenta rked rlc ev	To B	James Joseph Bro	snan				Pauli	ne Mar	ie Ko	ppers		
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "netural", or Iteme 23a or 28a-1 show empty figury or other traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (Туре, Print)			g Address (Street a						Code)
≥, ≥	and lealth m 27		Margaret P. Morri	s/ Sister	COL DI		Heritage						
банттоге	it of H		20a. Method of Disposition 1 Buriaf 2 □ Cremation 3 □				sition (Name of natory or other place	1	Date		c. Location -	-	
	it. Pa irtmen rtant: njury		4 □Donation 5 □ Other (Specifical Service Licer		Resu		ion Cemet Name and Addres				linton		
n o	permi Depa Impo eny ir		1 Phi	1			6000 Anna						al nome
h			23a. Part1. Enter the disease, or com	pfications that caused t	the death.								Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	Luna		AP*							Onset and Death
	/Medical		resulting in death)	Due to (or as a	conseque	ence of):							8 19091113
	Examiner		Sequentially list conditions,	b									
	pe tis	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	ence of):							
	xecut and	хап	that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence of):							
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Ď	tificat ng phy as th	ledi											
OC	th certendir	hysician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2			Ectopic pregnancy				23d. Da	e of delive	ery Day Year
	the ettern the ettern hed for u	/sici	1 Yes 2 SNo	4□Pregnant at t 9□ Unknown	ime of dea	ath 5□	Other (specify)	 			Wio	1101	Day real
Ĺ	requires that the een signed by th nould be detache	Δ.	Part II. Other significant conditions of	ontributing to death but	t not resul	fting in the ur	nderlying cause give	en in Part I.	23	3e. Did toba	cco use cont	ribute to t	he cause of death?
coras,	uires signe d be	d by		•		•	,			1 Yes	2□No	3 Prot	pabfy 4 □Unknown
Ö	w req	iete							24	la. Was an	24b. \	Nere auto	opsy findings available
ŭ L	: The law cete has b page 2 s	ompieted					<u></u>		_	autopsy performe	od?	prior to co death?	impletion of cause of
VII		e C	25. Was case referred to medical					26. Place of	Death (Chec	Yes 28	ZINO	165	
> 10	hysic his ce I direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatien	t 2 🗆 E	R/Outpatien	t 3□ DOA Othe	er: 4 🗆 Nursi	ng Home 5	Residen	ce 6 🗷 Oth	er (Specii	nouse.
<u> </u>	ing P		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of fnjury (Month, Day	Year)	28b. Time of Injury	28c. Injury Work			escribe how	injury occur	ed	
IVISION	ttend death stor: /	icati	2 Accident investigation 3 Suicide 6 Could not be		n. At hon	mo torm at-		res 2 □ No		ontion /Sten	ot and Mumb	De or Pur	al Route Number.
<u>></u>	after Direction by	ertification;	4 Homicide determined	28e. Place of Injur building, etc.	(Specify))	вет, гастогу, отпсе		Cit	ty or Town,	State)	er or nure	ar Houte Number.
	spita nours nerel	ai C	29a. Certifier 1 Certifying Ph	ysician: To the best of	f my know	vledge, death	occurred at the time	e, date and p	place, and du	e to the cau	se(s) and ma	inner as s	stated.
	To the Hospital or Attending Physicien: within 24 hours alter death. To the Funerel Director: After this certifical completely filled in by the funeral director,	edicai	(Check only 2 Medical Examone)	niner: On the basis of and manner stat	examination	on and/or in	estigation, in my op	oinion, death	occurred at th	he time, date	e and place,	and due to	o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				29c. License				i. Date signe		
			Doull Urm	- ULP			D2140	2		D	ecenine	r 1,2	2 000
	10		30. Name and address of person who Parm Movre MD	completed cause of de	ath (ftem	23a) (Type,	Elicott	City 1	4et 211	042			
	Sta	te	31. Date filed (Month, Day, Year)	32. Pø gistra	r's Signate	ure	4	20191					
	Registr		DEC 0 6	2006		ure A	mess.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** Ernest Joseph Burton Jr. 5 2006 December 10:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1419 Virginia Avenue Severn Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Min. Months 1 X M 2 □ F Hours 006-26-9684 Director June 24 1931 Maine Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medica Examiner must be notified at Director MD Anne Arundel 1 ☐Yes 2 ☐No Severn 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1419 Virginia Avenue 21144 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1950-70 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🙀 No Specify: Specify: 2 White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Sergeant First Class 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Ernest J. Burton, Sr. Mary Olive Jeddrie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trait Amalie Burton (Wife) 1419 Virginia Avenue, Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 12-7-2006 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 851 Annapolis Road, Gambrills, MD 21054 23a. Part. Enter tire dig ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in fail ire. List only one cause on each line. Approximate Interval Between Onset and Death Immed ate Caus (Fin I di earle or condition r sulling in deat I) **Physician** moule /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 214 No certificate has page 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this funeral (28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: Natural Accident Injury 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

Baltimore, Maryland 21215-0036

5 ☐ Pending investigation 6 Could not be determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number > 3 9 5 0 5

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yudhish Markan 305 Hospital, Drive, Glan Burnie, MD. 2106)

State Registrar

Medical

31. Date filed (Month, Day, Year) DEC 0 6 2006



	1 - For State Registrar	State of Marylan		ment of I ficate of			iene	06	4106
	1. Decedent's Name (First, Middle, Last)				-111 - 12 - 111	2. Date of Deat			3. Time of Death
Physician /Medical Examiner	Marilyn Jeanne 4a. Facility Name (If not institution, give s		41	b. City, Town, o	or Location of Death	December	Day 05, 2		11:00 p
LAGIIIIICI	Brooke Grove Nurs	ing Home		Sandy	Spring		Mon	tgome	rv
Funeral Director	Social Security Number 6. Sex	7. Age (In yrs.		Under 1 Year lonths Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Aug. 24,	Year)		lace (State or Forei
	Usual Residence of Decedent								
and Mental Hygiene. is marked other then "naturel", or items 23a or 28s-f show reumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	10a. State 10b. County Maryland Montgome		y, Town or Locati Silver Sj					1	0d. Inside City Limit 1 ☐ Yes 2 🔀 N
or 28	10e. Street and Number			10f. Zip Code		10	0g. Citizen of V	What Coun	itry?
23a	15016 Eastway Dr	ive		2090	5		Unit	ed St	ates
or items 234	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	.S. 13. Was	Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		e - Americ k, White,	
1月	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 X No If Yes, Give		Yes 2⊠ No					etc.
Exar d by	3 Widowed 4 Divorced	Year or Dates:		103 223110	ороспу.		Specify	Wh	ite
t, the Medical S Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	cation completed) College (1-4or 5+)	16a. Decedent (Give kind life. DO	t's Usual Occup d of work done NOT use retire	during most of work	ing	16b, Kind of Bu	usiness/Ind	dustry
1 6	12	0011090 (1 101 01)	Homer	naker			0wn	Home	
event,	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M			
To B	Derwood Gibson				Ruth N	ewman			
	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailing A	ddress (Street	and Number or Rur		City or Town,	State, Zip	Code)
rtre	Michael Basile /	Spouse			Drive, S				
othe	20a. Method of Disposition	20b. F	Place of Disposition	on (Name of			20c. Location		
50	1 Burial 2 XCremation 3 R	emoval from State	cemetery, cremato						
uniu .	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License				tory 12/1				Maryland
eny injury or other treumatic e once.	21. Signature di Fullerali Service Conse		Simi 1040	ole Tri D_Rockv	ess of Facility bute Fune ille Pike	ral and , Rockvi	Cremat:	ion C aryla	enter nd 20852
ician	23a. Part1. Enter the disease, or complic shock/br heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death e cause on each line.			ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
edical miner	resulting in death) Sequentially list conditions,	Due to (or as a conseq	uence of):						
ial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq							
o bur	resulting in death) Last	Due to (or as a conseq	uence of):						
etached for use as the Physician/Medi	in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3 □Ect	topic pregnanc	у		23d. Dat	te of delive	ny Day Year
hysic	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown		(0,000)/ _					
b b	Part II. Other significant conditions con	tributing to death but not res	ulting in the under	rtying cause gr	ven in Part I.	23e. Did tob			e cause of death?
shot.						24a. Was ar	245 3	Mara auto	
page 2 should						autops	y 5	prior to condeath?	psy findings availab npletion of cause of
g O	25.11					1 ☐ Yes 2	140	Yes	2□ No
Be	25. Was case referred to medical examiner?	ospital:		0#	26. Place of Deat				
al dire	1 ☐ Yes 2 No	1 Inpatient 2		3 DUA		me 5 Reside			1)
uo.	1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe ho	w injury occuri	ed	
ed in by the funera Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street,		Yes 2 No	28f. Location (Sti City or Town	reet and Numb , State)	er or Rura	l Route Number,
To the Funstei Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification; To Be Complete the	29a. Certifier 1. Certifying Phys (Check only 2 Medical Examir one)	ician: To the best of my kno ler: On the basis of examina	owledge, death oc tion and/or invest	curred at the tri	me, date and place, opinion, death occur	and due to the ca	use(s) and ma	nner as st	ated. the cause(s)
Med Med	29b. Signature and title-of certifier	and manner stated.		29c. Licens	no number	.,,	Od Data signa	d (Manth	One Variable
2 9 1	1/1/AA	Physician			0055694		9d. Date signed		7, 2006
	1 11/01 1 07/64	. , ,		1	7267	f	17656 P	6 0	11 2000
7	30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type, Prin						
7	30. Name and address of person who co ALOK MATH 31. Date filed (Month, Day, Year)	,	n 23a) (Type, Prin P+ 108		ney, MD	2083	2_		

	4	For State Registrar	State of Man		partment of Hertificate of L			ene g. No. 006	41069
		Decedent's Name (First, Middle, Las	it)				2. Date of Death		3. Time of Death
Physici					Brooks		December	7 200	
_/Medic		Margaret 4a. Facility Name (If not institution, give	Marie			Location of Death		4c. County of D	
Examir	er				Hance	_		Washi	naton
	3.00	2589 National Pik		n yrs. last birthda		If Under 24 Hrs.	8. Date of Birth	9 1	
Funeral		1	□M 2VE	, V	Months Days	Hours Min.	Jan. 13	Year)	Birthplace (State or Foreign Country) ashington, DC
Director		214-44-3645		83 Yrs.			Jan. 13	, 1923 W	isiting con, be
Du ≱		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or	Location				10d. Inside City Limits
aryla eho	=		aton	Иол	ncock				1 ☐ Yes 2√2 No
Ba-f	Director	MD Washin	igton	1101			1/	og. Citizen of What	Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or itema 23a or 28a-f ehow any injury or other traumatic event, the Mudical Examiner must be notified at once.	je l	10e. Street and Number			10f. Zip Code			og. Citizen di vvilat	Country
15 w	- B	2589 National Pi	.ke			21750		U.S	
dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 1	Was Decedent of Hi if Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
within 72 hours after death with the Maryland ene. then "naturel", or itema 23a or 28a-f ehow the Medical Exeminer must be notified at	교	1 Never Married 2 Married	1 □ Yes 2 No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify:	white
ours F	by	3 X Widowed 4 ☐ Divorced	Year or Dates:						WILTOO
2 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. De	cedent's Usual Occupative kind of work done	ation during most of work		16b. Kind of Busine	ess/Industry
n 7	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retired	1)			
r the	E 0	8	,		homemake	r		own h	ome
Hygent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M	Maiden Sumame)	
d be ental	To B	Herbert	Cole			Grace	9	Bailey	
d Me mari	F	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street	and Number or Ru	ral Route Number,	City or Town, Stat	e, Zip Code)
12 s h an 7 ls trau		Joanne M. Lanham,		120	8 Delaware	Ave C	hurchton.	MD 2073	3
dealt dealt im 2	10	20a. Method of Disposition			sposition (Name of	Ave., a		20c. Location - City	
I Italia		11 Burial 2 ☐ Cremation 3 ☐	I	cemetery, o	rematory or other place	1	3.0		
Pag ment: ury		4 Donation 5 □ Other (Specify	y) (So. Mem	orial Gard	ens 12/1	2/2006 I	Dunkirk,	MD
perting y injury		21 Signature of Funeral Service Licer	nse		22. Name and Addre	ss of Facility R	ausch Fur	neral Hom	e, P.A.
Depre any i		- Darkar	1 / Lule.	ach	8325 Mt. H	armony L	ane, Owir	ngs, MD 2	0736
		23a. Part1. Enter the disease, or com	plications that caused th	e death. Do not	enter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1	4				Onset and Death
Physician /Medical		disease or condition resulting in death)	a	DAAN.	~ te				1 110 7
Examiner			Due to (or as a c	consequence of):					
	_	Sequentially list conditions,	b	construction of					
D #	ine	if any, leading to immediate cause. Enter Underlying	Due to (or as a c	consequence on.					
cate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c						
an a		1930(kilg in ddati) Last	Due to (or as a t	consequence of):					
te b ysic	dlcai		_ d.						-
tifica ng ph as th	Med				1000	_			
death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		3 Ectopic pregnancy	,		23d. Date of	
atte d for	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at tir		5 Other (specify)			Month	Day Year
at the de by the a	S	9 Unknown	9□ Unknown						
E B B		Part II. Other significant conditions of	contributing to death but	not resulting in th	e underlying cause giv	en in Part I.	23e. Did tol	bacco use contribu	te to the cause of death?
uires sign d be	by						1 🗆 Ye	es 2 No 3	Probably 4 Unknow
w requ	Completed							1	
elaw hasb ge2st	pie						24a. Was a autops	y prior	e autopsy findings availab to completion of cause of
ysician: The l is certificate he director, page	0						perform 1 ☐ Yes		h? Yes 2□ No
	a)	25. Was case referred to medical				26. Place of De	ath (Check only or	10)	
Physician: this certific ral director,	0 0	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpa	atient 3 DOA Oth	ner: 4 Nursing H	lome 5 Reside	ence 6 □Other (Specify)
Phys rthis rat di	5	27. Manner of Death	28a. Date of Injury (Month, Day)		e of 28c. Injur	rv at		ow injury occurred	-,,,
ding F	0	1 Dending 5 Pending		Year) Inju		rk? Yes 2 □ No			
Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be		At home form			28f Location (S	treet and Number of	or Rural Route Number,
or At after d Direct in by	E	4 Homicide determined	building, etc.	(Specify)	, street, factory, office		City or Town		in fibrar floate frambor,
rs af	ပီ								
hou uner ly fill	a		hysician: To the best of miner: On the basis of e						
ne H n 24 ne F	edicai	one)	and hanner state						
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ž	29b. Signature and title of certifier	1/		29c. Licens	se number	1	29d. Date signed (A	fonth, Day, Year)
. > - 0		Mollne	h VA	1 1 -	D 8	777	3 1	110-	M-7 7.M
35	1	30 Name and address of person who	completed cause of do	ath (Itom 22a) /T-	rne Print)	1300			1
2		30 Name and address of person who	Completed cause of dea	201 (Junior 1284).(1) 	1111	1 had al	w. (().	0. 0 101	Ral
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S STATE OF C	-	31. Date filed (Month, Day, Year)	oz. negistlar	3 Olymature			A 1		
	tate	NEC 1	7 2000 -	Parties . A.	Search !	7	11-	a one 1.	La da A
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DHMH 17 Rev 1/2001

State

Registrar

6 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Ira Benton Cox December 2006 1240 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 E1kton Union Hospital ELKTON

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 20, May 20, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□F Yrs Virgínia 62 230-62-2327 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in then "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 💢 No Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 United States 240 Union Church Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 📉 No Specify: Specify: φ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Automobile Elementary/Secondary (0-12) College (1-4or 5+) Electrician Manufacturing injury or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be I Depertment of Health and Mental I Important: If Item 27 te marked o Dora Hubbard ဂ Dallas Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 240 Union Church Road, Elkton, Maryland 21921 Linda S. Cox/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) December 20a. Method of Disposition 20c. Location - City or Town, State Gilpin Manor Memorial Park 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) 22, 2006 Elkton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 onc. Mester 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 00 211000 /Medical Due to (or as a consequence of): Examiner SHE Sequentially list conditions, if any leading 1, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (gr Examiner a consequence of To the Hospital or Attending Physicien: The law requires that the death certificate be executed ete hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy rmed? 2UX No 1 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 & Inpatient 2 ER/Outpatient ဥ 3□ DOA Magner of Death
Natural
Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6

DHMH 17 Rev 1/2001

8

State Registrar 30. Name and address of per

31. Date filed (Month, Day Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

pleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

32

Please Type or Print in Black Indelible Ink

Manyland / Department of Health and Mental Hygiene Charles Columbus Crenshaw

aries Columbus	3 State of Mail For State Registrar Ameno#4b PerMF0P0C12-7 1. Decedent's Name (First, Middle, Last)	yland / Department of He -06cr Certificate of De	ath	eg No. 2005 Time of Death
/Physician edical Examiner		bus Crenshaw, III	Month December	
	4a. Facility Name (if not institution, give street and 2900 St. Clair Drive	,	ty, Town, or Location of Death nple Hills Temple Hills	4c. County of Death Prince George's
Funeral Director	5. Social Security Number 6. Sex 1 M 2	M	noths Dave House Min	th(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Wash, DC
e Maryland or 28a-f show any fied at once.	Usual Residence of Decedent 10a State 10b. County Maryland Prince George:	10c. City, Town or Location Temple Hills		10d Inside City Limi 1 X Yes 2 N
with the Maryland ins 23a or 28a-f sho be notified at once.	10e Street and Number 3617 Riviera Street	10f	Zip Code 1 20748	og Citizen of What Country? United States
		d Forces? If Yes, s	pedent of Hispanic Origin? (Specify Yes or No pecify Cuban, Mexican, Puerto Rican, etc.) 2 X No specify:	14. Race - American Indian, Black, White, etc Specify: Black
5-0036 led within 72 hours after deatl Hygiene other than "natural", or ite the Medical Examiner must Completed by Fun	15 Decedent's Education (Specify only highest Elementary/Secondary (0-12) Colleg	ge (1-4 or 5+) during most or	sual Occupation (Give kind of work done working life. DO NOT use retired)	16b. Kind of Business/Industry
21215-0036 ald be filed within 72 hours Mental Hygiene marked other than "natu event, the Medical Exan To Be Completed	12th 17. Father's Name (First, Middle, Last) Charles C. Crenshaw		18.Mother's Name (First, Middle, I	·
Should be fill and Mental F.7 is marked matic event, To Be	19a Informant's Name/Relationship (Type, Print Denise Crenshaw/Mothe) 19b. Mailing Add	ress (Street and Number or Rural Route Nur viera St.; Temple Hil	nber, City or Town, State, Zip Code)
Baltimore, MD 2121 permit Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event, TO Be	20a Method of Disposition 1 Burial 2 X Cremation 3 Remov	20b. Place of Disposition crematory or other p		20c. Location - City or Town, State 6 Alexandria, VA.
Baltim permit Pa Departmen Importan injury or	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name	and Address of Facility Pope Fune Marlboro Pk; Forestv	ral HOmes
Physician /Medical	23a Part I. Enter the disease, or complications the failure. List oply one cause on each line. Immediate Cause (Final disease a, Multiple	nat caused the death. Do not enter the mo	ode of dying, such as cardiac or respiratory arr	
Examiner	International Court (1 miles and 1 miles a	as a consequence of):		
ted Insit Examiner	if any, leading to immediate Due to (or cause Enter Underlying Cause	as a consequence of): as a consequence of):		
'60, ate be executed bhysician and ne burial - transit		ED		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Contributation: To Be Commissed by Physician/Medical Expedical Contributation:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 L Yes 2 No 9 Unknown 9 L	yes, outcome of pregnancy ive birth 2 Fetal di regnant at time of death 5 Other Inknown	eath 3 Ectopic pregnancy (Specify)	23d Date of delivery Month Day Year
Division of Vital Records, P.O. Box 687 ral or Attending Physician: The law requires that the death certific rs after death. al Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the original partitication. To Be Commisted by Physician!		ng to death but not resulting in the under	1 Ye	obacco use contribute to the cause of death? s 2 No 3 Probably 4 Unknow
Records, The law requires ficate has been significate has been significate has been significate has been pleaded.			24a. Was autoj perfc 1 🗹 Yes	prior to completion of cause of death?
certifi rector,	25. Was case referred to medical examiner? Hospital:	Inpatient 2 ER/Outpatient 3	26 Place of Death (Check only one) DOA Other Nursing Home 5	Residence 6 🗸 Other: Scene
Division of Vital Recoi To the Hospital or Attending Physician: The law within 24 dours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 si control Certification: To Re Comp	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Date of Injury Month, Day, Year) POUND: POUND:		how injury occurred
Division of spital or Attending loours after death. Increase Director: After filled in by the funer.	2 Accident Investigation 3 Suicide 6 Could not be determined (Spec	Place of Injury - At home, farm, street, factify) Multi-Family Apt.	or Town,	Street and Number or Rural Route Number, C State) r Drive, Temple Hills, Md.
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		e best of my knowledge, death occurred asis of examination and/or investigation, ner stated	at the time, date and place, and due to the cau in my opinion, death occurred at the time, date	se(s) and manner as started and place, and due to the cause(s)
	29b. Signature and title of contifier	dif-	29c. License number O.C.M.E.	29d Date signed (Month, Day Year) December 4, 2006
CR (3)		Medical Examiner 111 Pen	n Street, Baltimore, MD 21201	
Stat Registra		2. Registrar's Signature		
OHMH 17 Rev 1/200		ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 09:00 A M **Physician** 11 2006 CHRISTOPHER RAE MAXINE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Peninsula fegional Medical Center salista NICOMICO 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number Year) Months **Funeral** Days Hours 1 ☐ M 2 🗓 F March 18, 1936 Maryland 220-32-1651 Usual Residence of Decedent Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at XIX Yes 2 □ No Crisfield Somerset Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21817 311 Locust Street - Apartment] Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☐XNo Specify: Specify: Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Vorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Department permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If item 27 is marked other tha any Injury or other traumatic exceptions. Clerk's Assistant 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rachel Riggin Reynold McCready ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26427 Old State Road - Crisfield, Maryland 21817 <u> Nicki Lynn Wilson (Daughter)</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBunal 2 ☐ Cremation 3 ☐ Removal from State Crisfield, Maryland 12/14/06 Sunnyridge Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradshaw & Sons Funeral Home 21. Signature of Funeral Service Licensee Mary Beth Bradshaw-Pruitt 306 W. Main Street - Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kneumania **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician s the burial Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Christo pher 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 → 1 Impatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death. To the Funeral Director: After this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 5 mona

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

roust. Salubury mb 21501

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

		1	For State Ragistrar	State of Marylan		artment of H tificate of L			eg. No. 2 0 0 6	41074
ı	Physicia		1. Decedent's Name (First, Middle, Last) JAMES ELLISON	COLEMAN, JR				2. Date of Dear Month DECEMBER	Day Year	3. Time of Death 4:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of Death		4c. County of Dea	
			CHARLOTTE HALL VE				TE HALL		SAINT N	
	Funeral Director		210-14-3444	7. Age (In yrs. 85	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day FEB 2	9. Bir C. 1921 M	thplace (State or Foreign ountry) ARYLAND
	yland	- H	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mar-1 et	iç	MD QUEEN AN	NE'S	GRASON	VILLE				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	Og. Citizen of What C	ountry?
	23a	la	30 GRASONVILLE TE				538		USA 14. Race - Ame	- ince ledice
980	s I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, Ita Medical Examinatment be notified at	by Fun	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (S) n, Mexican, Puert Specify:	o Rican, etc.)	Black, Whi	te, etc. VHITE
21215-0036	within 72 ho ene. then "netu te Medicel	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wor	king	16b. Kind of Business	
7	filed wi Hygien sther th	Col	8		WA	TERMAN	10 Mather's Non	no /Eiset Middle	MAKINE, Maiden Surname)	SEAFOOD
P	be fill stal H od oth	Be	17. Father's Name (First, Middle, Last)	T TYMAN				REBECCA 1		
78	should be nd Mental marked o	ပ္	JAMES ELLISON CO		19h Mailir	ng Address (Street			r, City or Town, State,	Zip Code)
Maryland	and 2 sl salth an n 27 le r		KAREN OERTEL/ NIEC						EVILLE, MD	
Baltimore,	permit. Pages 1 an Depertment of Heal Important: If Item 2 eny Injury or other once.		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		cemetery, cres	osition (Name of matory or other place [LLE CEME]	TERY 12-8	Date 8-2006	20c. Location - City of STEVENSVIL	
Balti	permit. Depertre Imports eny Inju		21. Signature of Foheral Service Livense		FF	2. Name and Addrese LLOWS, HE	LFENBEIN	& NEWNAL	M FUNERAL MD 21619	HOME, P.A.
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	th. Do not ent	ter the mode of dyin	g, such as cardiad			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Due to a sa a consecuence	lyspi.	asia				0.000
	/Medical Examiner		resulting in deathy	Due to (4) as a consec	quence (bt):	by lat	200			
	*	Jer	Saturentially list conditions, if any, leading to immediate	Due to (or as a consec		Viana				
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
60,	icate be executed physicien and s the burial-transit	EX	resulting in death) cast	Due to (or as a consec	quence oi):					
38760,	physicate sthe	edicai								
.O. Box (The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of 9 □ Unknown	aldeath 3[□Ectopic pregnancy □ Other (specify)	<i>'</i>		23d. Date of de Month	elivery Day Year
σ.	signed by d be detac	ρ	Part II. Other significant conditions cor	tributing to death but not re	sulting in the u	inderlying cause giv	en in Part I.		obacco use contribute	1
Records,	e law requir has been si e 2 should	Completed						24a. Was autop	an 24b. Were a prior to death?	sutopsy findings available completion of cause of
alF					,			/		s 2 No
Vital	Physician: rthis certific ral director,	o Be	25. Was case referred medical examiner? 1 Yes 21 No	lospital:	TER/Outpatio	nt 3 DOA Oth	- /	ath (Check only o	ne) lence 6 □Other (Sp	acity)
o	ding Phys h. After this funeral di	 	27. Man Death 1 Deatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of		y at		now injury occurred	о спу)
Siol	ttendir death. ctor: Al	catic	2 Accident investigation 3 Suicide 6 Could not be	L			Yes 2 □ No	Opt Leasting (6		2 and Claude Marchae
Division	Te te d	Certification	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory, office		City or Tox	Street and Number or F m, State)	Rurai Houle Number,
_	To the Hospital capital capital capital structure at the Funeral D completely filled in	Medical C	29a. Centifier (Check only one) 1 Cartifying Physical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	th occurred at the till nvestigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	as stated. le to the cause(s)
	othi othi ompli	₩ W	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mor	nth, Day, Year)
	⊢ \$ ⊢ ō		AMMOW HO			Do	0 60 120		12/4/0	
			30. Name and address of person who co		m 23a) (Typa	Print)	ince Fra	ederick	12/4/0	20678
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign						
	Regist	rar	DEC 8 21	106 100	H	Acart.				

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			1 - For State Registrar	State of Ma			nt of He te of D			giene Rog. No	11116	5	41075
	Dhyoisi	0.0	1. Decedent's Name (First, Middle, La.		Ο 1 4 Δ		,		2. Date of De.			ar	3. Time of Death
do.	Physici /Medio		MATILDA		EMA				DEC	. 3	, 200	6	10:00P ^M
	Examir	er	4a. Facility Name (If not institution, give Laurel Region		tal	1	y, iown, ort aurel	ocation of Deat	n	1	. County of D		EORGES
September 1	Funeral Director		5. Social Security Number 577-38-4639 6. S	ex 7. Age ☐ M X ☐ F	(In yrs. last birthday 91 Yrs.		er 1 Year S Days	If Under 24 Hrs Hours Min		th y. Year) 5 , 1	915	Countr	ce (State or Foreign y) ginia
	land W		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	_ocation						10	d. Inside City Limits
	Mary	tor	MD Prince	e Geo	Ве	elts	ville	:					1 Yes 2 □ No
	h with the 23a or 28i	Funeral Director	10e. Street and Number 3580 Powder I	Mill Rd,	#103	10f. 2	ip Code 20	705		10g. Cit	U.S.		y?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or itema 23e or 28e-f show many joury or other traumatic event, the Marcial Exertings and be notified at 2005.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	ver in U.S. 13.		edent of His ecify Cuban	panic Origin? (S , Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		14. Race - A Black, V Specify:		tc.
21215-0036	within 72 ho	Completed	15. Decedent's Et (Specify only highest gra		(Giv	e kind of v DO NOT	ual Occupat vork done du use retired) mesti	ring most of wo	rking	16b. K	ind of Busine		ustry
Q 2	filed v Hygie other t	e Co	9th 17. Father's Name (First, Middle, Last)			טט.			me (First, Middle,	Maiden			
/lan	Mental Mental rrked	To Be	Woodson Bar						Cox				
, Maryland	and 2 sho salth and a n 27 is ma		19a. Informant's Name/Relationship (Pamela Houston	^{Type, Prin} Grand n (Daugh	ter) 358				Rd, #1				^{Code)} 20705 le,MD
altimore,	iges 1 at of He in item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of Disp cemetery, cre	ematory of	other place,	1	Date /7.4 /06		ocation - City		
Ħ	entmer entmer ortant injury		4 □ Donation 5 □ Other (Specifical Service Corners)	/	Marylar	NG IN 22. Name	AT I PSY and Address	Mem 12	OWDEN 3	ьа: FUN:	ureı, ERAL	HOM	IE, P.A.
ä	Depermine Depermine Important Irreportant		Evm2 Kig	Sundl									ID 20850
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	he death. Do not er e. gestive				c or respiratory ai	rrest,		1	Approximate nterval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):								
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	scuted nd transit	Examiner	Cause (Disease or injury that initiated events	0.	umonia								
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P.O. Box	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic □ Other (pregnancy specify)				23d. Date of Month		/ Day Year
rds, P.	quires that in signed by uld be deta	by	Part II. Other significant conditions of Demen		t not resulting in the	underlying	cause giver	in Part I.		obacco u Yes 2	_		cause of death?
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Vita	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Other		ath Check only o				
ō	p Phys er this eral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time		28c. Injury	4 Nursing r	lome 5 ☐ Resid			Specify)	
Sion	ending sath. or: Afte	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury	М		es 2□No					
Divis	tal or Att rs after de al Direct	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	treet, facto	ory, office		28f. Location (S City or Tox			r Rural i	Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the best of niner: On the basis of and manner state	examination and/or i	ath occurre	d at the time on, in my opi	o, date and place nion, death occu	e, and due to the urred at the time,	cause(s) date and	and manne d place, and	r as stat due to t	ted. he cause(s)
	To t To t	Σ	29b. Signature and title of certifier			2	9c. License	number		29d. Da	te signed (M	lonth, D	ay, Year)
•	3		30. Name and address of person who	to MD)		200	045	34	12	-1410	6	
			SRICATHA CA	completed cause of de	V17300	VA	AN D'	USEN	ROAD	LA	URE	41	MD-20701
ā	Sta Registi		31. Date filed (Month, Day, Year) DEC - 8	JE. Hagistia		Crash							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Registrar Certificate of Death Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Chase **Physician** 0123 actober 2006 Norman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EASTON ALBOI HOSPITAL MEMORIAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 12M 2DF 213-24-2072 March 6, 1929 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ortant: If Item 27 is marked other then "naturel", or items 23a or 28a-f ehow injury or other traumatic event, the Madical Examiner must be notified at 1 PYes 2 No Director Cambridge)Orchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21613 USA Avenue FOIRMOUNT Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 208 No Specify: If Yes, Give Year or Dates: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 1957 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Frozen Foods Truck Driver permit. Pages 1 and 2 should be life Department of Heelth and Mental Hyg important: If item 27 is marked other any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chase Murray Isadore 4gnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 801-Eairmount Ave. Cambr. dge, MD. 216 Chase -eah MD. 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State Salem, Maryland Mt, Pleasant Cometery 10/21/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Home, P.A. Henry Funeral dge, MD. 21613 510 washington St. Cambri 23a. Part1 Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Jailure. List only one cause on each line. Atherosclerotic Cardiovascular Disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ending physicien and use as the burial-transit Due to (or as a consequence of): EXAMINER After this certificete has been signed by the ettending physicien tuneral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ERTIF in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yas 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Cholelithiasis 2 No 3 Probably 1 🗌 Yes 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2,□No within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 1 Inpatient ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel [To the Hospitel 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20 306 10/13

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

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2006

DHMH 17 Rev 1/2001

of death (Item 23a) (Type, Print)

32. Registrar's Signature

06-09491 Earl Dunbar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For State Certifica Registrar	te of Death Reg. No. 2005 117
Physician/ 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year December 13, 2006 0555 hrs
Medical Examiner Ear1 Dunbar 4a Facility Name (if not institution, give street and number)	December 13, 2006 4b. City, Town, or Location of Death 4c. County of Death
Prince George's Hospital	Cheverly Prince George's
Funeral 5 Social Security Number 6. Sex 7. Age (In yrs. last birtho	Foreign
Director 579-90-6323 Usual Residence of Decedent 43	Yrs Months Days Hours Min. 11/20/1963 Foreign Country Wash., DC
pu we sal LO DC	Washington 1 X Yes 2 No
DC 10e. Street and Number 10e. Street and	10f. Zip Code 10g. Citizen of What Country?
भू हुँ <mark>व</mark> 4073 Grant St., NE	20019 United States
DC 10e. Street and Number 4073 Grant St., NE 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1. We 2 with the Ward Forces? 1. We 2 will be so the Ward Force of the Ward Fo	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc African
5 E L 3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify: Specify: American
15. Decedent's Education (Specify only highest grade completed)	ecedent's Usual Occupation (Give kind of work done uring most of working life. DO NOT use retired)
Elementary/Secondary (0-12) College (1-4 or 5+)	Audio-Visual Tech. Private
To be dearned and the state of	18.Mother's Name (First, Middle, Maiden Surname)
Very many partial and the property of the prop	Ginger V. Thompson
To plan be to be t	Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Earl Dunbar/Father 20a Method of Disposition 20b. Place of	4073 Grant St., NE Wash., DC 20019 Disposition (Name of cemetery, Date 20c Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State	ry or other place)
The state of the s	w Memorial Park 12/21/2006 Landover, MD
BB and a single state of the single state of t	Stewart Funeral Home 4001 Benning Rd., NE. Wash., DC 20019
Physician 23a. Pair I. Enter the disease, or complications that caused the death. Do not	enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
farure. List only one cause on each line. Immediate Cause (Final disease a. Cocaine intoxication	Death
or condition resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
events resulting in death) Last Due to (or as a consequence oi).	
between the second of the seco	863, 1/24/07 TT , pen/E, 2863, 1/2/07 TT
O a residual to the female: 23c. If yes, outcome of pregnancy	23d Date of delivery
past 12 months?	
The law requires that the death of the law requires that the death of the law requires that the death of the latter of the latte	7/25
Part II. Other significant conditions contributing to death but not resulting Sarcoidosis Sarcoidosis	in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown
Sarcoidosis	24a. Was an 24b. Were autopsy findings available
Records, The law requires ficate has been significate has been significate has been significant has been significa	autopsy prior to completion of cause of performed?
	1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 V ER/Ou	26.Place of Death (Check only one) utcatient 3 DOA Other4 Nursing Home 5 Residence 6 Other.
The spiral of th	Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
28b. T 27. Manner of Death 1 28a. Date of Injury (Month, Day, Year) 28b. T 1 Natural 5 Pending Investigation Fnd 12/13/2006 Fnd	1 5:13 am 1 Yes 2 X No unknown
The law required to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Value of the process of t	rm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number City or Town, State) 40/3 Grant Street, N.L.
Suicide 6 X Could not be determined (Specify) found in mo	otor vehicle Washington, D.C.
29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and due to the cause(s) and manner as stated nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
one) 2 Medical Examiner: On the basis of examination and/or in and manner stated 29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
Warrett Brunthall and	O.C.M.E. December 14, 2006
30. Name and these of pers in who completed cause of death (Item 23a)	
2 30. Narie and a fress of pers in who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner State 31. Date filed (Month, Day, Year) Registrar DEC 2 0 2006	r 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

	1 - For State Registrar AMEND#23a(a)pe	State of Marylan			and Mer	ntal Hygier	211115	41078
Physician /Medical	1. Decedent's Name (First, Middle, Last ROBERT KA	ALVIN DUPPI	INS			Date of Death Month DEC . 2 ,	^{0ay} 2006	3. Time of Death
Examiner	4a. Facility Name (If not institution, give Casey House 5. Social Security Number 6. Se	2		ity, Town, or Location o Rockvil der 1 Year If Under 2	le		MONTGO	MERY
Funeral Director	213-82-4618 Usual Residence of Decedent	M 2□F 7. Age (my/s. 46	Yrs. Mont		Min.	Date of Birth (Month, Day, Yea Lr. 22,1		nplace (State or Forei untry) ryland
Ba-f show		omery 10c. Cit	ty, Town or Location	ver Sprin	g			10d. Inside City Limi
23a or 2	10e. Street and Number 44 Bailey's	Court	10f.	Zip Code 20906		10g. (U.S.A.	untry?
led within 72 hours after deeth with the Maryland yglane. yglane, naturel', or items 23a or 28a-f show it, the Medical Examinar moust be nutified at the Medical Examinar moust be nutified at Completed by Funeral Director	11. Marital Status **X2*Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 XNo If Yes, Give Year or Dates:	If Yes,	cedent of Hispanic Origonous Cuban, Mexican, Secrity Cuban, Mexican, Secrity:	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	14. Race - Ame Black, White Specify: B	
within 72 h lene. Then "natu The Mexical Ompleted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		1	Usual Occupation work done during most Tuse retired) Jery Drive			Kind of Business/	•
permit. Pages 1 and 2 should be filed within 72 hours Dependent of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", any injury or other traumatic event, tra Medical Exa once. To Be Completed by	17. Father's Name (First, Middle, Last)	ppins		18. Mother	r's Name (Fi	irst, Middle, Maid e Sue I	en Sumame)	II DOOLS
and 2 sho lealth and m 27 ie m her traum	19a. Informant's Name/Relationship (7) Hattie Sue Dur	pins (Mothe	er) 707	ess (Street and Number W. Washi	ngton	St,Ab	beville	AL36310
it. Pages 1 rument of H rumt: If ite	20a. Method of Disposition 1 Burial 2 XCremation 3 1 4 Denation 5 Other (Specify, 21. Signature of Funeral Service License	Removal from State Ri	Place of Disposition (cometery, crematory) Liverdale	Park Cre	12/6	/06 R:	iverdal	e, MD
Deperiment of the control of the con	21. Signature of Funeral Service License	Lund	246	and Address of Facility N. Washi	ngton	St,Ro		
The law requires that the death certificate be executed to the law requires that the tending physicien and the page 2 should be detached for use as the burial-transit to proper the page 2 should be detached for use as the burial-transit to proper the page 2 should be detached for use as the burial-transit to proper the property of the page 2 should be detached for use as the burial-transit to property of the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the purity of the page 2 should be detached for use as the purity of the page 2 should be detached for use as the purity of the page 3 should be detached for use as the purity of the page 3 should be detached for use as the purity of the page 3 should be detached for use as the purity of the page 3 should be detached for use as the purity of the page 3 should be detached for use as the purity of the page 3 should be detached for use as the purity of the page 3 should be detached for use as the purity of the page 3 should be detached for use as the purity of the page 3 should be detached for use as the purity of the page 3 should be detached for use as the page 3 should be detached for use 3 should be detached for us	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)	uence of):	noma				Onset and Death
es that the death certitical gned by the ettending phice detached for use as the by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	il death 3 Ectop	c pregnancy (specify)			23d. Date of deli Month	very Day Year
w requires may been signed b should be deta	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying	ig cause given in Part I.		23e. Did tobacci		the cause of death?
cete hes been si page 2 should Completed						24a. Was an autopsy performed?	death?	topsy findings availat completion of cause of 2 No
hysicien: The his certificate of director, pag	25. Was case referred to medical examiner? 1 □ Yes 2☒ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3			heck only one	6 MOther (Sner	w Hospic
ding P	27. Manner of Death 1 Natural 2 Accident 3 Suicide 5 Pending investigation 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d.	. Describe how in		IOSOIC
Ital or ral Dir led in I	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif				City or Town, Sta		
thin 24 hours ethin 24 hours ethin 24 hours ethin 24 hours ethin mpletely filled	29a. Certifier 1 X Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	red at the time, date and ion, in my opinion, deat	d place, and th occurred a	due to the cause at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
within 5 comp	29b. Signature and title of certifier Cyrithia M			29c. License number H00580	32		Date signed (Month	
	30. Name and address of person who c Cynthia M. Wil	liams, M.D.	6001 Mt	ıncaster 1	Mill	Rd.,Ro	ckville	,MD 2085
State Registrar	31. Date filed (MontBECYear) 7	32. Signatura Si	ture from	es .				

Box 68760. P.O. Division or Vital Records,

Baltimore, Maryland 21215-0036

within 24 hours af **To the Funeral D** completely filled in 10

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Par, Year)

Hyung T. Kim M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

32. Registrar's Signature

Medical

State

Registrar DHMH 17 Rev 1/2001 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29 S. Greene St. Baltimore, MD.21201

29c. License number

D0057354

29d. Date signed (Month, Day, Year)

2006

21925, BOY TIANA

		Flease	YPE OF Print in Bla MIND ITTH On D State of Maryland			ental Hygiene	egible.	
				Certificate of	f Death	Reg. No.	306 4	1080
	Dharaisisa	1. Decedent's Name (First, Middle, Last,				2. Date of Death Month Day		. Time of Death
	Physician /Medical	DIDIC IDOM	DuBOSE, III		1	Month Day December 2	2006 3	5:30 P.M.
	Examine	4a Fecility Neme (If not institution, give			4b. City, Town, or Loc		ounty of Death	
		Shady Grove A	dvantiet Hoe	ni+al	Doglari	110	MONTEGON	
-	Funeral	5. Sociel Security Number 6. Sec		birthday) If Under 1 Yes	Rockvi ar If Under 24 Hrs.	8. Date of Birth	MONTGOM 9. Birthplace	
	Director	N/A	M 2□ F	Yrs. Months Day	s Hours Min.	8. Date of Birth (Month, Day, Year) 12-2-06	Maryl	(State or Foreign
		Usuel Residence of Decedent			0 19		Platyl	allu
	/lenc	10a. Stete 10b. County	10c. City, T	own or Location			10d.	Inside City Limits
	Man Man	MD Montg	omerv	Germantow	'n			1 XYes 2 No
	with the Marylence of 28s-f show	10e. Street end Number	2	10f. Zip Code		10g. Citiz	en of What Country?	,
	72 hours after deeth with the Marylend natural", or items 23s or 28s-f show disal Examiner must be notitied at sted by Filmeral Director	20410 70010	II name					
	eeth	20418 Apple	Harvest Clr 12. Was Decedent Ever in U.S.		20876	ifu You or No.	S.A. I. Race - American	Indian
_	in i	1 Never Married 2 Married	Armed Forces?	If Yes, specify Cu	Hispanic Origin? (Speciban, Mexican, Puerto P	lican, etc.)	Black, White, etc.	
5	urs aft	3 Widowed 4 Divorced	1 Tyes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 N	o Specify:	5	Specify: Bla	ck
5	hou hou	15. Decedent's Edu		Sa Dagadantia Hayal Oca	unation	16h Via	of Business/Indust	
Ö	n 72	(Specify only highest gred		6a. Decedent's Usuel Occ (Give kind of work don	e during most of workin red)	g Tob. Kin	or business/indust	ry
7	ed within 72 ho ygiene. her than "naturi it, the Medical	Elementary/Secondary (0-12)	College (1-4or 5+)					
7 3	Hygid It	17. Father's Neme (First, Middle, Last)		N/A	18 Mother's Name	(First, Middle, Maiden S	/A	
<u></u>	ntal H od oth	77	co Tr				umame)	
Š	I Men I Men				Tiana	Briggs		
2	and its m	19a. Informant's Name/Relationship (Ty	pe, Print)	9b. Mailing Address (Street	et and Number or Rurel	Route Number, City or	Town, State, Zin Co	^{de} 20876
- -	treent of Haalth tant: If Item 27 ijury or other tr	Tiana Briggs (M	other)	20418 Appl	e Harvest	Cir, #J,	German	town,
5	2 2 2 7 7	20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ R	code	of Disposition (Name of tery, crematory or other p	lace)	Date 20c. Loc	ation - City or Town,	State
	Pag ment: I ury o	4 □ Donetion 5 □ Other (Specify)	Rive	rdale Park	Crem 12	2/6/06 R:	lverdale	, MD
	permit. Par Departmen Important: any injury once.	21. Signature of Funeral Service License	e //	22. Nama and Add	ress of Facility SNO	DWDEN FUNI	ERAL HOM	E, P.A.
۵	SSEE	Mougo.	X X 4	246 N. W	<i>l</i> ashingtor	St, Rocky	/ille,MD	20850
		23a, Part1. Enter the disease, or compli	cations that caused the death. If	not enter the mode of de	ving such as cardiac or	respiratory arrest	An	proximate
	DI	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	e cause on each line.	7	ying, saori as cardiac or	respiratory arrest,	Int	erval Between
	Physician /Medical	Immediate Ceuse (Final		. 1 1	1 72 1 10	alc ancieti	2) 12	12106
	Examiner	disease or condition resulting in death)	Teriviable	Newsorn 6	it as we	SESTIN		1-1-6
	-		Periviable Due to (or es Pulmonary	a consequence of):	414		12	12106
	sit ed	t	Tulmonary	Immatu	117			•
	executed in end itel-trensit	Sequentially list conditions, if eny, leading to immediate	Pulmonary	a consequence of): hyperte			12	12106
Š	cian curie	cause. Enter Underlying Cause (Disease or injury	fulmonary	hyperter	4)/2/0		, ,	10102
000	fficata l physical se that	that initieted events resulting in death) Last	Due to (or as	a consequence of):				2/2/06
9	ing p		Profound	hypothers	nia		•	
2	nat tha death certi d by the ettending latached for use e							
	a dee	Part II. Other eignificant conditions con	tributing to death but not resulting	g in the underlying cause o	iven in Part I.	23b. Did tobacco u	se contribute to the	cause of death?
	at the	Maternal ch	-110 amnionit	ک ا		1 ☐ Yes 2 🔀	No 3 Probabl	y 4 🗆 Unknown
ń	gned bedg						- 22	
coras,	Tha law raquiras the sate has bean signed page 2 should be completed by	Placental Abo	up+10N			24a. Was an autops		autopsy findings ole prior to
2	s be shown		•			performed?	comple of deat	etion of cause
ב	a la	Maternal Coa	aub pathies			4.57 V		
9	Fig. 2		year processing			1 ☐ Yes 2 🔀	NO 1LIYE	es 2 No
5	s certifi irector	25. Was case referred to medical examiner?	ospital:	5	ther:			
5	this rald	1 ☐ Yes 2 ☐ No 27. Menner of Death	1 Month inpatient 2 L EH/	Outpatient 3D DOA	4 LI Nursing Hom	e 5 Residence 6		
5	After funa	1 Matural 5 ☐ Pending	28e. Date of Injury (Month, Day Year) 28t	Injury W		od. Describe now injury	occurred	
7	tent for: tha	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	00 50 41		Yes 2 No			
<u> </u>	tal or Attending P rs after deeth. al Director: After t led in by tha funari Certification:	4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	rarm, street, ractory, office	9 /20	If. Location (Street and City or Town, State)	Number or Hurai Ho	oute Number,
1		00- 0-48	1					
	in 24 hours in 24 hours he Funer pletely fill edical	(Check only 2 Medical Examin	ician: To the best of my knowled er: On the basis of examination	ige, death occurred at the end/or investigation, in my	time, date and place, ar opinion, death occurred	nd due to the cause(s) a	nd manner as stated	d. cause(s)
	the I	One)	and manner steted.					
	To To the Total	29b. Signature and title of certifier	1 1 1 1 - 1		nse number 1942		signed (Month, Day	
	1	> grown,	Jeoneto 12515F	27	772	Dece	uber 3,	100
	•	30. Name end address of person who co		a) (Type, Print)				
		INEZ REEVES	MD 9901 MEDICA	L CENTER DA	ZIVE ROCKY	ILLE MD		
		31. Dete filed (Month, Day, Year)	1,0,0	C 00/11/01				

		ľ	For State Registrar	State	of Marylar		artment of F		Mental H	ygiene Reg. No	2000	41081
	Physici /Medic		1. Decedent's Name (First, Middle, L Gertrud S.		ırgin				2. Date of Decem		, 2006	3. Time of Death 7:03 P M
	Examin		4a. Facility Name (If not institution, g 6001 41st Avenue	ive street and nu	ımber)		4b. City, Town, o		ith		County of Deat	_
Ì	Funeral Director		5. Social Security Number 578-14-6418	Sex 1☐M 2∭XF	7. Age (In yrs 93	. last birthday) Yrs.		If Under 24 Hr Hours Mir		Birth Pay Year) /1913	9. Birt Co Germ	hplace (State or Foreign untry) any
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	e Mary	ctor	MD Prince	George's	в Ну	attsvi1	lle					1√2 Yes 2 □ No
	with the	i Director	10e. Street and Number 6001 41st Aven	ue			10f. Zip Code 20782			-	izen of What Co ed Stat	
336	should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other than "natural", or items 23a or 28a-1 show imatic event, if a Marilcal Enantical cast La notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed F	2 X No ive		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or I irto Rican, etc.)		14. Race - Ame Black, White	rican Indian,
Maryland 21215-0036	within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	rade completed) (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	orking		ind of Business/	ŕ
nd 2	al Hygie 1 other vent, 1	Be Cc	17. Father's Name (First, Middle, La			Sec	Lecary		ame (First, Mida			
<u> </u>	should band Ment a marked umatic e	ြို	Alfred Schicht 19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	Anna Ba		ber. City o	or Town, State, 2	Zip Code)
	1 and 2 sho Health and tem 27 is my other traum		Frank Durgin (S			7907	Crows Ne	st Court	Apt #	12 L	aurel, M	D 20707
Baltimore,	o to to		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Contents)		State	rt Line	osition (Name of matory or other place coln Ceme	tery 12,	Date /8/2006	Bre	ocation - City or entwood,	, MD
Balt	permit. Pag Depertment Important: I any Injury o once.		21. Signature of Funeral Service Lic	ensee	-		2. Name and Addre		rt Lind Road	coln Bren	Funeral twood, N	Home 1D 20722
	Physician		23a. Part1. Enter the disease or co shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on	each line.		ter the mode of dyir	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death 1 minute
	/Medical Examiner		resulting in death)		o (oras a conse onic Hyp		ion					10 years
	pe is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	(or as a conse							
8760,	icate be executed physician and s the burial-transit	dicai Examiner	resulting in death) Last	c. Due to	(or as a conse	quence of):						
9	ing phy:	0	IF FEMALE:	d					·			
P.O. Box	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12-months? 1 Yes 2 No 9 Unknown	1 ☐ Live	utcome of pregr birth 2 ☐ Fet pnant at time of nown	al death 3	⊒Ectopic pregnancy ⊒ Othe <i>r (specify)</i> _			-	23d. Date of del Month	ivery Day Year
	res that signed b	by	Part II. Dther significant conditions		death but not re	sulting in the u	ınderlying cause giv	en in Part I.			_	the cause of death?
corc	w require been signal	ieted	Atril Fibrill	ation	<u>_</u>				24a. W			Itopsy findings available
= Re		Completed						-		topsy formed?	death?	completion of cause of 2 No
Vita	sician certifi rector	Be	25. Was case referred to medical examiner? 1 ¬yyes 2 ¬ No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Oth	00	eath (Check only		6 □Other (Spe	
n of	tending Physicath. tor: After this the funeral di	on: To	27. Manner of Death 1★Natural 5 □ Pending	28a. Date		28b. Time o	of 28c. Injur	y at k?	28d. Describ			cny)
Division of Vital Records,	= 0 0	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Plac	e of Injury - At I ding, etc. (Spec		M 1 □	Yes 2 □No		(Street ar		ıral Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	aminer: On the	basis of examin	nowledge, deat nation and/or in	th occurred at the tire	ne, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s e, date an) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	i / 4	nner stated.	· Ía	29c. Licens	_			ite signed (Monti	
) ,	(25)	à	30. Name and ad ress of person wh		use of death (Ite	-		2582		Ve	cember	6,2006
-{			Alfred Munzer 31. Date filed (Month, Day, Year)	MD 76	00 Carr	oll Av	e. Takom	a Park,	MD 2091	.2		
5	Sta Regist		DEC 0 7 2006	Beneva	Registrar's Sign	Speck						

The law requires that the death certificate be executed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #12 per FH/PHYS 12-11-2006tife to Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3:03 PM December 6 2006 Winfred Day /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ★M 2 ☐ F 73 217-32-2488 July 27, 1933 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at 1 ☐Yes 2X No Director Damascus Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20872 U.S.A. 12640 Prices Distillery Road Funeral . Was Decedent Ever in U.S. Armed Forces? 1 XYes 22 Was If Yes, Give Year or Dates 1951—1953 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if them 27 is marked other than "naturar", or iten any injury or other traumatic event, the Medical Examinarione. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐XNo Specify. Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Protection Services U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Bea11 Titus Deets ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24611 Burnt Hill Road, Clarksburg, Maryland 20871 Domini H. Bean - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Bethesda Meth. Cemetery 12/11/06 Browningsville, Md. 5 Other (Specify) 4 Dollation 21. Signature of Funeral Service Linensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home Damascus, Maryland over 26401 Ridge Road, 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of) **Examiner** Coliti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 11 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Natural 5 Pending investigation 1 Yes 2 No 2 Accident after death 6 ☐ Could not be 3 Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 💢 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Em Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

To the Hospital or Attending Physician:

State Registrar

Hemen Shah 31. Date filed (Month, Day, Year) DEC 0 8 2006

29b. Signature and title of certifier

Thomas 65 egistrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Johnson Drive Frederick MD 21702

29c. License number

D0060417

29d. Date signed (Month, Day, Year)

Physician Martha C. Davis Morcester Lee's Almost Home Assisted Living S. Social Security Number S. Social S				For State Registrar	State of Mary		artment of H		-	giene Reg. No.200	6 41083
Control of Discosing							rimouto or i	504111	2. Date of De	ath	
State			Martha C. Davis								
Social Security Number 10 to 12 to 15				4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of De	ath		
Social Security Number 10 to 12 to 15				Lee's Almost Home	Assisted La	iving				Worces	ter
Continued Cont				5. Social Security Number 6. Sex	7. Age (II	n yrs. last birthday,			rs. 8. Date of Bird in. (Month, Da	th y, Year)	Birthplace (State or Foreign Country)
The State The County The County The County The County The State The County The S		Director		217-34-2848	1111 2121	69 Yrs.			2 2	1 1937	MD
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The part of the pa		uted d ansit	F	cause. Enter Underlying Cause (Disease or injury	Cheron	4	in h.	رد هیچال			
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25. Was case referred medical examiner? 25. Was case referred medical examiner? 26. Place of Death (Check only one)	Rec	he lav s has ge 2	m	Mary Insu	(-8				- autop	osy pri	or to completion of cause of
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		Sta					break)			7,	1

State of Maryland / Department of Health and Mental Hygiene 61084 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Herbert T. Dare 8:00 PM Dec 3, 2006 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Annapolis Nursing & Rehabilitation Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 □XM 2 □ F 217-26-8151 76 Mar 7, 1930 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Annapolis MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 U.S.A. 130 Hearne Rd. Apt. 1112 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify:Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Custodian 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Eliza Dare Henry Dare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3824 Regency Parkway Apt. 301 Suitland, MD 20746 Timothy Dare/son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/8/06 4 ☐ Donation 5 ☐ Other (Specify) Lothian, MD Moses Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home lip 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Months Myelodyspiasia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? billor-e 2 1 No 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 🖪 No 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 🖳 Matural 5 Pending 1 🗌 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Physician ///adical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0020

item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at

injury or

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Physician/Medical Examiner

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Completed

Be

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Certification:

Medical

Funeral

Director

signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, has After this certificate To the Hospital or Attending Physician:

efter death. Director: Aft

within 24 hours e To the Funeral C

State Registrar

31. Date filed (Month, Day) 2006

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 4203 QUEENSBURY POPHYATEVILLE MD 20787 MO 32. Registra s Signature

4b. City, Town, or Location of Death

BETHESDA If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min.

10f. Zip Code

1 ☐ Yes 2 🗓 No

16a. Decedent's Usual Occupation

Banker

21793

(Give kind of work done during most of working life. DO NOT use retired)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

DECEMBER

18. Mother's Name (First, Middle, Maiden Surname)

Ikuko Gloria Narusawa

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8. Date of Birth (Month, Day, Year)

AUG. 28,1955

2006

MONTGOMERY

Maryland

States

Financial Institution

14. Bace - American Indian Black, White, etc.

Specify: White

16b. Kind of Business/Industry

4c. County of Death

10g. Citizen of What Country?

United

3:19

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Examiner **Funeral** Director r 28a-f show notified at with the be "natural", or items 23a o Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene. Internate than "natural", or ite marked other than "natural", or ite Jry or other traumatic event, the Medical Examine. Jry or other traumatic event, the Medical Examines. Baltimore, Maryland 21215-0036 permit. Page Department of Important: If any Injury or

Physician

/Medical

DANNY LEE DIXON

5. Social Security Number

216-66-1550

10e. Street and Number

11 Marital Status

10490

10a. State

Director

Funeral

þ

Completed

Be

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

OF

. Was Decedent Ever in U.S. Armed Forces?

Dixon

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

HEALTH

10c. City, Town or Location

Walkersville

51

NATIONAL INSTITUTES

10b. County

Harp Rd.

15. Decedent's Education (Specify only highest grade completed)

VITBERG

Year)

QEC 1 1 2006

Maryland Frederick

1 ☐ Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Physician /Medical Examiner

burial-tra attending physician for use as the buria ed by the a signed by t page 2 s certificate funeral director. After 24 hours after death Funeral Director: filled in by

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Dona 1d ပ 19a. Informant's Name/Relationship (Type, Print) Wendy Dixon / Wife 20a. Method of Disposition Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown à Completed Be 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide Medical 29a. Certifier (Check only

DAVID

31. Date filed (Month, Day,

Α

10490 Harp Road / Walkersville, Maryland 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glade Cemetery 4 Donation 5 Dother (Specify) DEC. 12,2006 Walkersville, MD 21. Signal r of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1100 N. Maple Ave. / Brunswick, MD 21716 23a Part. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death NTRAVASCULAR DISSEMINA TETS HRS Due to (or as a consequence of): LHRONIC MYFLOID Due to for as a consequence of: Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □ Ectopic pregnancy Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☑ Yes 2 ☐ No autopsy performed? 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗹 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1∏Yes 2∏No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0064307 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

within 2.

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32. Pogistrar's Signature

CENTER DRIVE,

BETHESDA,

MARYLAND

20892

			For State		-	•	artment of				20	0.0	11000
			1 - State Ragistrar Amend #18 1. Decedent's Name (First, Middle,	_per_FH/PI Last)	HYS 12-	14-20	06'CNM	Dealin		2. Date of Dea		Ub_	3. Time of Death
	Physicia /Medic		EMMA	I.	DAUB	BER				Month Decembe	r 6, 20	Year 106	9:45 A M
	Examin		4a. Facility Name (If not institution,		per)		4b. City, Town	, or Location	of Death		4c. Coun	y of Death	
			Crumland Farms 5. Social Security Number		Center		Fred	lerick	24 Hrs.	9 Date of Birt		deric	Nace (State or Foreign
ı	Funeral Director		579–50–6130	1 M 2 X F	100	Yrs.	Months Day		Min.	8. Date of Birt (Month, Day NOV . 19	, Year) 1906	Cour	nington, DC
	ס		Usual Residence of Decedent								,		
	ehow	'n	10a. State 10b. County Maryland Fre	derick		. Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Director	10e. Street and Number				10f. Zip Code)			10g. Citizen of	What Cour	
	h with		7252 Windsor	Pass			217	710			Unit	ed St	tates
	eme S	Funerai	11. Marital Status	12. Was Decede		S. 13.	Was Decedent o	f Hispanic Ori	igin? (Sp	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americ	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 If Yes, Give Year or Date		į	1□Yes 2√√ N				Spec		ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow the Musical Exercitar most be notified at		15. Decedent's	s Education			dent's Usual Occ				16b. Kind of I	Business/In	dustry
212	thin 7: e. an "n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	or 5+)	(Give life.	kind of work dor DO NOT use reti	ne during mos ired)	st of work	ing			
7	ygien ygien th		12]	Homemake					nome	
Maryland	ould be filed v Mental Hygie wrked other t	Be	17. Father's Name (First, Middle, L Wilhelm	August	Egolf			Mat	ilda itilda	Clara		me)	
Ž	should nd Me mark mark	2	19a. Informant's Name/Relationshi		Lgoll		ng Address (Stre				162		Code)
	alth a 127 io		Caryl Barnett	/ daughte:	r	7252	Windso	or Pass	s / A	damstow	m, Mar	yland	21710
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Mudical Examinating the notified at ADG.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 DRemoval from St		ace of Dispo	sition (Name of matory or other p	nlace)	ı	Date	20c. Location	- City or To	own, State
Ĕ	Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Sp.	ecify)			Hill Ce			3,2006			DC
Bai	Depar Depar Impor eny in		21. Signature of Funeral Service L	censee	-		2. Name and Add						01700
	W		23a. Part 1. Enter the disease, or o	complications that cau	used the death		621 Opos er the mode of d					, MD	21702 Approximate
	Physician		Immediate Cause (Final	nly one cause on each	th line.								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or	as a consequ	ience of):	Trai	1 1	nJ	12110-	٦		1019/2
	Examiner		Sequentially list conditions,	b									
	led	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ience of).							
	execun n and al-trar	Exan	that initiated events ' resulting in death) Last	c. Due to (or	as a consequ	ience of):						-	
8760,	ate be executed hysicien and the burial-transit	cai		d									
0x 68	death certificate be executed e ettending physicien and ad for use as the burial-transit	Med	IF FEMALE:									7//2	-
BO	ath ce	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2		h 2 ☐ Fetal	death 3	Ectopic pregnar					ate of delive onth	ery Day Year
o	the de y the iched	nysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9□ Unknow	nt at time of de	ath 5	Other (specify)						
ر <u>.</u> ص	Physician: The law requires that the death certifica this certificate has been signed by the ettending phraid director, page 2 should be detached for use as it.	by Pt	Part II. Other significant condition	s contributing to dea	th but not resu	lting in the u	nderlying cause	given in Part I	l.	23e. Did to	bacco use con	tribute to th	ne cause of death?
Records,	en sig	ted t	Dement	9				· · · · · · · · · · · · · · · · · · ·		1 🗆 Y	es 200	3 Prob	ably 4 Unknown
ecc	lawr nas be a 2 sh	Completed	- Hype1	TENSIZ	25					24a. Was autop	sy	prior to con	psy findings available mpletion of cause of
<u>س</u>	: The cate h		1/1/0h	414 A	A.	14	Disun	50		perfor 1 ☐ Yes	med? 2000	death? 1 ☐ Yes	
⋚	sician certifi irector	Be	25. Was case referred to medical examiner? 1 Yes 2 46	Hospital:		FD/0				Check only o			
Division of Vital	g Phy er this	n: To	27. Manner of Death	1 ☐ Inp 28a. Date of (Month,		28b. Time o	I 3 DOA	9 LIN		me 5 Resid			<u>y) </u>
ion	Attending r death. ector: After by the fune	atio	1 Adatural 5 Pending 2 Accident investiga	ation	Day rear)	Injury		Yes 2□	No				
Ν	or Attend efter death Director: A	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	of be 28e. Place of building	f Injury - At ho , etc. (Specify	me, farm, str	eet, factory, offic	: e		28f. Location (S City or Tow		ber or Rura	I Route Number,
	To the Hospital or Attending Physician: The law within 24 hours elter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Certifying	Physician: To the h	act of my know	uladaa daat	h conversed at the	time data a	nd aleso	and due to the c			1-1-4
	Hospital 24 hours e Funerel [letely filled	edicai		Physician: To the b examiner: On the bas and manna	is of examinat	ion and/or in	vestigation, in m	y opinion, dea	ath occur	ed at the time,	date and place	, and due to	the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	1.	×		29c. Lice	nse number			29d. Date sign	ed (Month,	Day, Year)
)	4		1 (ARM	2/1	me /	47	MDD	16428			12	17/	06
	Q		a chi	no completed cause, MD / 300	TT 4	Minah	C+ / T	rederi	ck.	Marvlan	d 2170	1	
	Sta	to	Casper CLine 31. Date filed (Month, Day, Year)	32.	gistrar's Signat	tur i	Casti?	LUGULI					
	Registr		DEC 1	2006 32. F	Muse .	JU , 169,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1050 740 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. 13 Med Hrunde 8. Date of Birth (Month, Day, June 27 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Hours 1**X**) M 2□ F 544-14-0256 85 Yrs. 1921 Oregon Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show If Health and Mental Hygiene. item 23 or 24 or 25 or 2 1 ☐ Yes 2 X No Director MD Anne Arundel Crownsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene. Int: If item 27 is marked other then "neturel", or Items 23a or 2 21032 413 Chestnut Trail Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1. □ No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify Specify White If Yes, Give Year or Dates: 1942-72 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy Chief Engineman 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Toeves Frank Einfeldt ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 914 Coulson Road, Crownsville, MD 21032 Elizabeth Hall(Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 0 = 0 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: if any injury or once. 12-08-2006 Maryland Vet Cem. Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Picansee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 851 Annapolis Road, Gambrills, MD 21054 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician rteriosalerotic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, the planting of the fact cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 ☐ Inknown 1 ☐ Yes 2 ☐ No leted 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Compl has page 2 2 No certificate 1 ☐ Yes To the Hospitel or Attending Physiclen: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 P/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 3□ DOA 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 A Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) nu 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

DNES

egistrar's Signature

30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

DEC 0 6 2006

31. Date liled (Month

0105

State of Maryland / Department of Health and Mental Hygiene

		-	For State State Registrar	e of Maryland		ertificate of L			giene Reg. No. 2 A f	1. 1. 1. 0. 0.
	ž.		Decedent's Name (First, Middle, Last) AKA	A - James W		am Fisher,	III	2. Date of Dea	ath C	3. Time of Death
	Physicia /Medic	95. 1	JAMES WILLIAM	FISHER,	JR				er 16, 2	006 7:55 A ^M
	Examin	er 4	4a. Facility Name (If not institution, give street a FREDERICK MEMOR		TAL	4b. City, Town, or	Location of Death		4c. County o	DERICK
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		9. Birthplace (State or Foreign Country)
	Director		220-34-2847 Usual Residence of Decedent	66_	Yrs.			Sept. 1	2, 1940	
	yland now at		10a. State 10b. County	10c. City,	Town or I	Location				10d. Inside City Limits
	ne Mar 8a-f sl	Director	Maryland Frederick	Tusca	rora				10g. Citizen of Wh	1 □Yes 2NNo
	death with the Maryland ms 23a or 28a-f show r must be notified at		10e. Street and Number 4639 Old Licksville Re	and .		10f. Zip Code 21790				rat Country?
	death	Funeral	11 Marital Status 12. Wa	s Decedent Ever in U.S ned Forces?	. 13	3. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spento In, Mexican, Puerto		JSA 14. Race Black	- American Indian, White, etc.
20	be filed within 72 hours after death with the Marylar Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 💢 Married 1 ☐ If Y	Yes 2 X No es, Give or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify:	
-0036	2 hour		15. Decedent's Education (Specify only highest grade comp			edent's Usual Occup		ing	16b. Kind of Bus	White iness/Industry
2	within 7 ene. than "r he Med	Completed	Elementary/Secondary (0-12) Col	ege (1-4or 5+)	`life.	. DO NOT use retired	n)		5 5	
7 0	filed w Hygie other t		12 17. Father's Name (<i>First, Middle, Last</i>)		Тора	grapher 	18. Mother's Name			Mapping Agency
Ian	uld be Mental Irked c	To Be	James William Fisher				Martha Al	lice Lov	ve Fisher	<u></u>
Mary	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type. Prin			iling Address (Street				
	1 and Health tem 27		Carolyn M. Fisher, wi: 20a. Method of Disposition		4639 ace of Dis	Old Licks position (Name of rematory or other place	ا أ	Date	20c. Location - C	Maryland 21790 Dity or Town, State
Baltimore,	Page ent o nt: If		1 ☐ Burial 2 【A Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)	i from State		Maryland	12/10	/2006	Frederic	k, Maryland
Salti	permit. F Departm Importar any injui		21. Sonature of Funeral Service Licensee			22. Name and Addres	ss of FacilityKeer	ney and	Basford	Funeral Home
ы	g O = 8 0		23a Part For the disease or complications	M009		106 East C				Approximate
	Physician	1	23a. Part1. F the disease, or complication, shock, or heart failure. List only one cause Immediate Course (Final	e on each line.	24	to	lui.			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	ue to (or as a consequ	ence of):	away	5			
	Examiner	L.	Sequentially list conditions, b.	oue to (or as a consequ	once of):					
7.	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events at this is ideath), leaf	de to (or as a consequ	erice orj.					
ó	e exection and and and and and		resulting in death) Last	ue to (or as a consequ	ence of):					
68760,	ificate be executed g physician and as the burial-transit	edical	d							
Box 6	± 6 8			es, outcome pf pregnar					23d. Date	of delivery
	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No]Live birth 2 □ Fetal]Pregnant at time of de]Unknown		3 □Ectopic pregnancy 5 □ Other <i>(specify)</i> _	/		Mon	th Day Year
<u>Р</u>	uires that the de signed by the a Id be detached f		9 ☐ Unknown Part II. Other significant conditions contributions		Iting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use contri	bute to the cause of death?
Vital Records,	quires t n signe ald be (d by						10,	Yes 2□ No	3 ☐ Probably 4 ☐ Unknown
000 000 000	law requir as been si 2 should I	Completed						24a. Was	an 24b. W	Vere autopsy findings available rior to completion of cause of
ř	The lav	Com						perfo 1□ Yes	rmed? de	eath? □Yes 2□No
Z E	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Tyes 2 Mo Hospita	l: 1 ☐ Inpatient 2 ☑	D/Outpot	ient 3 DOA Oth	er:			r (Caraiti)
or	ding Phys h. After this (funeral dir	n: To	· 27. Manner of Death 28a		28b. Time Injur	of 28c. Inju	v at		dence 6 □Othe how injury occurre	· · · · · · · · · · · · · · · · · · ·
Sior	tendin eath. or: Aft the fun	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1□	Yes 2 □ No			
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28€	. Place of injury - At hor building, etc. (Specify	me, farm,	street, factory, office		28f. Location (3 City or Tox		r or Rural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in		29a. Certifier 1 CertifyIng Physician (Check only 2 Medical Examiner: C	To the best of my know	viedge, de	eath occurred at the ti	me, date and place	and due to the	cause(s) and mar	nner as stated.
	the Ho nin 24 the Fu	Medical	one) ai	nd manner stated.		29c. Licens				(Month, Day, Year)
	To To		29b. Signature and title of pertifier				1648			- 200 (
•			30. Name and address of person who complete	ed cause of death (Item	23a) (Typ					•
	12		Kusay Barakat, MD, 31	0 West Nint	th St	reet, Free	derick, M	aryland	21702-	6114
	Sta Regist		31. Date filed (Month, Day, Year) DEC 2 6 2006	63	A AS	carle)				
			10 4	4-4-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 Elaine Fales Dl c /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗙 F 69 214-36-0797 31, 1937 Director Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director WV Berkeley Falling Waters 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 61 Whippoorwill Lane U.S.A. 25419 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical than ' College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the M Registered Nurse Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Preston Nield Thelma Dale Paden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William L. Fales/Husband 61 Whippoorwill Lane, Falling Waters, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 12/21/2006 | Hagerstown, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami the burial-trans be execut and Due to (or as a consequence of) nding physician Box 68760 Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has this certificate 1 Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 ☑ Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. iours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 0 To the Hospital or within 24 hours aft To the Funeral D 29a. Certifier 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

State Registrar

q

Machan

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

		Pleas	e Type or Pri					•	
		For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of F rtificate of I		,	giene _{Reg. No} 2 () () 6	1,1090
A Physical Company		Decedent's Name (First, Middle,	Last)				2. Date of De	ath	3. Time of Death
Physici /Medio	al	JOSEPH ROBE			Ah City Town o	Lastin of Dank	DECEM	BER 2,200	
Examir	er	4a. Facility Name (If not institution, FREDERICK ME)				r Location of Death DERICK		4c. County of Dea	
Funeral			6. Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Aug	th 9. Bir	thplace (State or Fereign ountry) Washington
Director		Usual Residence of Decedent		77 Yrs.			Aug.	21, 1929	Washington
arylan show	<u>-</u>	10a. State 10b. County MD Fred	erick	10c. City, Town or Lo	fferson				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	Director	10e. Street and Number	STICK	36	10f. Zip Code			10g. Citizen of What Co	
tth with 23a or ust be	rai Di	6504 Mt. Chu	cch Rd.		21	755		USA	
Ind 21215-0036 be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4X Divorced	12. Was Decedent Armed Forces? d 1X Yes 2 ☐ tf Yes, Give Year or Dates;	No 1952-	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐ No	lispanic Origin? (Spe an, Mexican, Puerto Specity:	ecity Yes or No Rican, etc.)		
5-0036 72 hours af natural", or	eted	15. Decedent's (Specify only highest	s Education grade completed)	16a, Dece	dent's Usual Occup	ation	ina	16b. Kind of Business	/Industry
2121 ed within gjene. er than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired driver	during most of worki	''y	aab aa	
il Hygin	Be Co	17. Father's Name (First, Middle, L	ast)	Cab	driver	18. Mother's Name	e (First, Middle,	cab co Maiden Surname)	•
aryland 2 should be filed and Mental Hygi s marked other umatic event, t	ToE	Joseph H. F	-					M. Muelle	
Mand 2 strau		19a. Informant's Name/Relationshi		ster)801	Alison A	Ave., Me	chani		A 17055
Baltimore, permit. Pages 1 ar Department of Hea Important: if Item i any Injury or othe		20a. Method of Disposition 2 □ Burial 2 □ Cremation 4 □ Dogation 5 □ Other (Sp.			ap vete:	rans 12/		20c. Location - City or 5Flintsto	ne, MD
Baltimo permit. Page Department of Important: If any Injury or once.		21. Signature of Foreral Servicely	LON		OI E. M	ain St.,	Mlaa.	uneral Ho letown, M	me D 21769
Physician /Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	a Acu		dial ph	^	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
Examiner per tist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as	a consequence of):					
68760, ifficate be executed g physician and as the burial-transit		that initiated events ' resulting in death) Last	c Due to (or as	a consequence of):					
Box ath cert attendin or use	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	/		23d. Date of de Month	livery Day Year
Records, P.O. he law requires that the de has been signed by the s ge 2 should be detached t	þ	Part II. Other significant condition Diwhetis Wellit	ns contributing to death b	out not resulting in the u	nderlying cause giv	en in Part I. Afhiliay;	23e. Did to	obacco use contribute to Yes 2 □ No 3 □ P	o the cause of death? robably 4 □Unknown
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Vital Fictar: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	171111111111111111111111111111111111111	ot 3CI DOA Oth	26. Place of Death	(Check only o	ne)	
Jivision or Vital R or Attending Physician: The free death. Director: After this certificate h. in by the funeral director, page	7: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ury 28b. Time o	IL SEL DON	4 Nursing Ho		dence 6 Other (Spenow injury occurred	ecify)
SiOri ending sath. or: Aft the fun	atio	1 Natural 5 Pending 2 Accident investiga	ition	ay Year) Injury		Yes 2 □ No			
Division or tall or Attending Physical death. In Director: After this ed in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	20e. Place of In	jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office	To the state of th	28f. Location (8 City or Tov	Street and Number or R vn, State)	ural Route Number,
Division (To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner s	of examination and/or ir	h occurred at the tin extigation, in my c	me, date and place, opinion, death occurr	and due to the red at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	Σ	29b. Signature and title of certifier	W	Mn	29c. Licens	e number 7/78		29d. Date signed (Mon.	
BILL		90. Name and address of person w	the completed cause of the cause of the completed cause of the c	death (Item 23a) (Type,	tve for	Kathen.	Ma	217.14	
Sta	ate	31. Date filed (Month, Day, Year)	32. Fi gist	rar's Signature	1 4		. Al > (OVVID	
Regist		BEC (2 2000	wes it by	Confe!				

			1 - For State Registrar	State of M	laryland / Dep	partment of ertificate of			iene g. 2.005	41091
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month	h Day Ye	3. Time of Death
	/Medic		ANNA R. FEEMSTER			.,		DECEMBER	204, 200	
	Examir	ner	4a. Facility Name (If not institution, give		•		or Location of De	ath	4c. County of D	
		100	WASHINGTON ADVENT 5. Social Security Number 6. Sec		TAL ge (In yrs. last birthda)		OMA PARK	IS 9 Date of Birth		GOMERY
	Funeral Director			M XXF	84 Yrs.	Months Days				Birthplace (State or Foreign Country) VASHINGTON, DC
<u> </u>	Ţ.		Usual Residence of Decedent					A00. 10	9 1922 V	VASITINGTON, DC
	anylar show	-	10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
	Ba-f	Director	MD PRINCE G	EORGES	HYATTSVI					XIX Yes 2 □ No
	a or 2	ä	10e. Street and Number			10f. Zip Code	0.5	10	ng. Citizen of What	
	ns 23	Funerai	4922 LaSALLE ROAD	12. Was Deceden	t Ever in U.S. 13	2078		(Specify Vec or No	UNITED	STATES merican Indian.
S	r Her	듄	1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes XIX If Yes, Give	?			(Specify Yes or No- erto Rican, etc.)		/hite, etc.
ğ	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Exa., illustriust be natilised at	þ	XX Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes XX No	Specify:		Specify:	BLACK
21215-0036	d within 72 hours after death with the Marylan liene. I than "natural", or items 23a or 28a-1 show The Madical Examinational Langlilied at	Completed	15. Decedent's Ed (Specify only highest gra		(Giv	edent's Usual Occu	during most of w	vorkina	6b. Kind of Busine	ess/Industry
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Maryland	ld be ental ked o	To Be	MOSES E. ROBINSON					F. GAINES	alderi Samame)	
ary	should and Men Is marke	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mai	ling Address (Stree		Rural Route Number,	City or Town, Stat	e, Zip Code)
	Health a		RAYMOND ROBINSON	/ SON		ROCKVUE		BOWIE, MD		
ore	of He of He fiterr		20a. Method of Disposition 1 ☐ Burial ★ Cremation 3 ☐	Damoual from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ace)	Date 2	Oc. Location - City	or Town, State
<u>Ĕ</u>	Pages ment of ant: If it ury or o		4 □ Donation 5 □ Other (Specify)		ITAN CREN	ATORY 1:	2/08/06	ALEXANDI	RIA, VA
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked othe Important: If item 27 Is marked othe any Injury or other traumatic avant, once.		21. Signature of Funeral Service Licen) ()	1	22. Name and Addr MARSHALT	ess of Facility	RAL HOME O		
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	Physician /Medical		23a. Part. Enter the disease, or composition of the composition of the composition of the composition of the composition resulting in death)	a. Coro	ine.	ten D;		ac or respiratory arre	st,	Approximate Interval Between Onset and Death
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	D ::	iner	Sequentially list conditions, I any, leading to annualistic cause. Enter Underlying Cause (Disease or injury		s a consequence of):					
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<u>ra</u>	ilcian: Th certificate rector, pag	e e	25. Was case referred to medical				26. Place of D	1 ☐ Yes 21 eath Check only one		es 25 No
<u>~</u>	Physic this ce al direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpati	ent 2 ER/Outpatie	nt 3 DOA	hor	Home 5 ☐ Residen		pecify)
Division of Vital Records,	ding P h. After i funera	atlon;	27. Manner of Death 1 12 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time o lnjury	Wo		28d. Describe hov		
DIVI	or At ifter of Direct in by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
	To the Hospital or At within 24 hours affer or To the Funeral Direct completely filled in by	edical	29a Certifier 1 1 Certifying Phy (Check only 2 Medical Examone)	and manner st		th consumed at the ti evestigation, in my o	ine, date and plac opinion, death occ	te, and due to the cac curred at the time, dat	e and place, and d	as stated. ue to the cause(s)
	To To Con	Σ	29b. Signature and title of certifier	D. FI	ding mD	29c. Licens	SPSP		d. Date signed (Mo	onth, Day, Year)
_	(2)		30. Name and address person who c	ompleted cause of o	death (Item 23a) (Type	Print)	Hant 1:	7600 C	A	W4.
W.	Sta	te.	31. Date-filed (Month, Day, Year)			- VI 111-1	- Alike	1 9 Koma	Jack, N	ND. 20912
4	Registra		DFC 0 7 2006	seem b. B.	rar's Signature					

			For State Registrar	State of	f Marylaı		artment <i>rtificate</i>			and M	ental Hyg	jiene			92
	Di		Decedent's Name (First, Middle,	Last)		r					2. Date of Dea Month	th Day	Year	3. Time o	f Death
	Physici /Medio		Margene	Ray		Ferr	211				Decembe			7:45	рМ
	Examir		4a. Facility Name (# not institution,		nber)		4b. City, To	wn, or L	ocation o	f Death		4c.	County of Death		
			2500 Briggs Chane		** A . /k	1	Silv		oring	24 Uro	0.0		ontgomery		
	Funeral Director		5. Social Security Number 254–28–5108	6. Sex 1 ☐ M 2 🖼 🗗		last birthday) Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day	, Year)	9. Birth	place (State ntry)	or Foreign
			Usual Residence of Decedent		84						Aug. 17,	1922	Georg	gia	
	yland		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside C	ity Limits
	9 Ma	cto	Maryland Montgome	ry		Dei	wood							1 🗌 Yes	2 <u>√</u> No
	or 28	Dire	10e. Street and Number				10f. Zip C	ode				l0g. Citi	zen of What Cou	ntry?	
	ath w	ral	17817 Park Mill			10		855		: 0.40			USA		
	ltems	une	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Dece Armed For 1 ☐ Yes	rces?	J.S. 13.	Was Deceder If Yes, specify	nt of His Cuban	, Mexican	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)		 Race - Ameri Black, White, 		
336	urs af	by Funeral Director	3 Widowed 4 Divorced	If Yes, Giv Year or Da	е		1 🗌 Yes 2	No.	Specify:				Specifichite		
21215-0036	72 hours after death with the Maryland netural', or Items 23a or 28a-f show dital Examiner must be politied at	Completed	15. Decedent			16a. Dece	dent's Usual (Occupat	ion	t of condition		16b. Ki	nd of Business/In	idustry	
218	thin 7	nple	(Specify only highest Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use	retired)	ring most	OI WOIKII	19				
21	lad w lygiar her th		12			c	Clerical						Publishe	er	
and	be fill H	Be	17. Father's Name (First, Middle, L	,				'			(First, Middle,	Maiden	Sumame)		
ž	hould d Mai nark	2	Joseph Benjamin Ra 19a. Informant's Name/Relationsh	·		10h Maili	na Addrose /6	Street as			Hopkins	City	r Town, State, Zij	o Codol	
Maryland	d 2 sith an traul												LONGO DE LA CONTRACTION DE LA	Code)	
	Heal Heal tem		John D. Ferrell, J 20a. Method of Disposition	r./ Son	20b.	Place of Dispo	osition (Name	of		Denno	d, bryl	and 20c. Lo	20855 cation - City or To	own, State	
9	Pages ent o		1 № Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		state	cemetery, crea ce of Hea	-		l n	ecemb 200		o nome			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other then "netural", or Items 23s or 28s-f show may injury or other traumatic event, the Madical Examinat must be notified at ODGs.	3 1	21. Signature of Funeral Service L	icens <i>ee</i>							al Home I		r Spring,	reryta:	
œ	995.9		dames	Dan Q	7								, MD 20901		
			23a. Part1. Enter the disease, or c shock, of heart failure. List of	complications that canny one cause on ea	aused the dea ach line.	ith. Do not ent	ter the mode of	of dying,	such as	cardiac o	r respiratory arr	est,		Approximation Interval Bet	ween
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	/Medical Examiner		resulting in death)	Due to (or as a conse										
		<u>_</u>	Sequentially list conditions, if any, leading to immediate	b	or as a conse	guence of									
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Box	leath certifi attending I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	come of pregnirth 2 Fet		Ectopic preg	nancy				2	23d. Date of delive		V
O. E.	e dea the at	Physician/Med	1 Yes 2 No	4☐ Pregna 9☐ Unkno	ant at time of o	death 5	Other (spec	ify)					Month	Day	Year
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<u> </u>	ysici is cer direct	To B	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 🗆 Ir	npatient 2	ER/Outpatier	nt 3 DOA	Other					S ∰Other (Specif	Secon	dary
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Siol	endir eath. or: Al	catle	2 Accident investig	ation			М		s 2 🗆 N	No					
Division of Vital Records,	or Att	Certification:	3 Suicide 6 Could n 4 Homicide determin	Zoe. Flace	of Injury - At h ng, etc. (Speci	nome, farm, str ify)	eet, factory, c	office		2	8f. Location (Si City or Town		d Number or Rura	Il Route Num	ber,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying	Dhysician: To the	hast of mu kn	Suiladae desti	h	N 1	data and	1.01					
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	To the within To the	Me	29b. Signature and title of continer					icense r					signed (Month,		
}	15		>/W-+		-		1	10	04	43	7	De	cember	4/2	001-
	1)		30. Name and address of person v	no completed cause	e of death (Ite	m 23a) (Type,	Print)							-, -	
			Dr. Richard	Stefan	acci	32	50 St	41	ting	Cat	elt U	loal	cember bine 1	nd 2	1797
	Sta Registr		31. Date filed (Month, Day, Year)	32. 2	gistrar's Sign	ature	nasti s		0						
	riegisti	-11		/ LUUU P	100 ALR 1	CI FIN	200 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For MEND#29aperIME11/17/06, E.W., Maryland / Department of Health and Mental Hygiene State Registra MEND#23aII, 23e, 25-28fperIME11/17/06 Armitivate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 12, 2006 Physician 1:30 P M Howard Edward FRUITERMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 □ F 89 112-07-0301 Yrs. Director Oct. 6, 1917 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3310 N. Leisure World Blvd. #714 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \\ Yes 2 \sup \ No If Yes, Give Year or Dates: \\ WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No <u>۾</u> Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Fruchtman Beulah Baronsky 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1638 West Street, Stoughton, MA Nina Lane, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11/15/06 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Judean Memorial Gardens Olney, MD 21. Signature of Fureral Service 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carro 11 St. NV. Washington, DC

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arres.

Approximate Interval Between Onset and Death Immediate Cause (Final VENTRICULAR FIBRILLAT disease or condition resulting in death) Due to (or as a consequence of): SUBBURAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine BY CERTIFICATION Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Hypertension 1 ☐ Yes -2 ☐ 16 3 ☐ Probably 4 XUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) tX Yes ⊸≨ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Xnpatient ationt 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 XNo Fell. Oct.25, 2006

be executed physician and s the burial-tran attending p been signed by the should be detached Jas

Box

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Records,

Vital

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r 28a-f show notified at

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ns 23a o must be

"natural", or iter edical Examiner

the Medical

If item 27 is marked other or other traumatic event, the

Pages 1 and 2 should be nent of Health and Mental

Department Important: I any Injury o

Physician

/Medical

Examiner

Baltimore, Maryland

certificate To the Hosping.

within 24 hours after death.

To the Funeral Director: After a managed of the function of the

2 XAccident 3 ☐ Suicide 4 ☐ Homicide

6 ☐ Could not be determined

0645 M 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, 3310 N. Town Eisure World Silver Spring, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29a. Certifier

Nursing Home

00 5

29d. Date signed (Month, Day, Year) 11/14/06

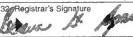
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5622 Shields Drive, Bethesda, MD Truong Bao, M.D.,

State Registrar

Medical

31. Date filed (Month, Day, Year) 2006 17 NOV



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Nambe Physician 10:10 AM CARRE 30 2006 TERRIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CONTER INIVERSITY OF MARYLAND MEDICAL If Under 1 Year | if Under 24 Hrs. 8. Date of Birth
Jun. 29, 1931 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 X M 2 □ F 75 216-32-7886 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 821 W. Saratoga Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No if Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritai Status Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. <u>م</u> 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Hote1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 01iver Garrett Pinkey Howard ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Angela Waul/niece P.O. Box 241 Port Republic, MD 20676 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Brooks UMC Cem. 12/06/06 St. Leonard, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sewell 21. Signature of Funeral Service Licensee Funeral Home Gladys 1451 Dares Beach Rd. Prince Fred., MD20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dun to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours a er death To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Janusez 30,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year)
DEC 6 2006

Blace & Signature

Registrar

BATHYORE, MD 21201

•	i		For State Registrar	State of Ma		d / Depa	artment of H	ealth and	Mental Hy		5 41095
			Decedent's Name (First, Middle, Last	st)					2. Date of De		3. Time of Death
	Physicia /Medic		Tavion Delonte	Gross					Novemb	oer 30 20	06 0931 AM
	Examin		4a. Facility Name (If not institution, give	street and number)	1/	1. 1	4b. City, Town, or	Location of Deat	h	4c. County of D	
			THE JOHNS H	OPKINS	HOM	141	DAH	If Under 24 Hrs	3	Balti	
	Funeral		5. Social Security Number 6. S 214–77–6754	ex 7.Ag Z⊓M2□F	e (in yrs. i	ast birthday) Yrs.	Months Days	Hours Min.	(Month, Da		Birthplace (State or Foreign Country)
	Director	1	Usual Residence of Decedent				1 10		Oct. 20	0, 2006 Ma	irytano
	ylend wow		10a, State 10b. County		10c. City	, Town or Lo	ocation				10d. Inside City Limits
	Mar m-f-et	ţo	Maryland Calvert		st.	. Leon	ard				1 ☐ Yes 2X No
	or 28	Oire	10e. Street and Number				10f. Zip Code			10g. Citizen of What	: Country?
	within 72 hours after death with the Marylend ene. Then "natural", or Items 23e or 28e-f ehow re Medical Exeminer must be motified at	Funeral Director	6757 Aralia Ave.				20685			United St	
	er de	nue	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	Specify Yes or No to Rican, etc.)	Black, W	kmerican Indian, Vhite, etc.
9	rs aft	by F	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	NO.		1 ☐ Yes 🏌 No	Specify:		Specify:	Black
3	thou stural	edit	15. Decedent's Ed	ducation		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busine	
<u>.</u>	nin 72	plet	(Specify only highest gra	de completed) College (1-4or :	5+1	(Give	kind of work done of DO NOT use retired	during most of wo 1)	orking		
7	be filed with tal Hygiene. d other then event, the M	Completed	N/A			N	/A			N/A	1
2	al Hy al Hy al Othe	Be	17. Father's Name (First, Middle, Last,							, Maiden Sumame)	
N N		2	Yardell Gross					Rebecca			
	s 1 and 2 should f Health and Mer item 27 ie marke other traumatic		19a. Informant's Name/Relationship (,			er, City or Town, Sta	
2	and fealth im 27 her tu		Rebecca Swain (Mo	other)	20h P		Aralia A	ve., St.	Leonard Date	d, Marylar 20c. Location - City	
Ē	ges it of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		0	emetery, cre	matory or other place				
	t. Pa rtmer rtent njury		4 Donation 5 Other (Special		Met					Alexandri neral Home	a, Virginia
מ	Depermination of the permit of		21. Signature of Funeral Service Licer	-11						Republic, Mar	
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	one cause on each li	noth	iorax					Approximate Interval Between Onset and Death HOUR
K 08/00,	leeth certificate be executed tatending physicien and I for use as the burial-transit	ical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C Due to (or as							
.c. Box	0 0 0	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	I death 3	□Ectopic pregnancy □ Other (specify)	<i>'</i>		23d. Date of Month	delivery Day Year
Γ	requires that the de seen signed by the a hould be detached f	Ď	Part II. Other significant conditions of Renal Failur			ulting in the u	inderlying cause giv	ren in Part I.		V	te to the cause of death?] Probably = 4 □Unknown
ecords		Completed	Catoliac DUS	Re Lunction	7				24a. Was		e autopsy findings available
r	0 - 0	E O)	0					auto perfe	ormed? deat	
	an:] tificel tor, p	0	25. Was case referred to medical					26. Place of De	eath (Check only		103 22110
_	ysici ils cer direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpati	ent 2	ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Res	idence 6 Other (Specify)
ion or	or Attending Physician: Th iffer death. Director: After this certificete in by the funeral director, peg		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inji (Month, Da	ıry ı <i>y Year)</i>	28b. Time o Injury	Wor	yat rk? Yes 2 ⊡No	28d. Describe	how injury occurred	
DIVISION	iel or Attendest s after desti si Director: ad in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		jury - At ho tc. <i>(Specif</i>	ome, farm, si	reet, factory, office		28f. Location (City or To	(Street and Number own, State)	r Rural Route Number,
	To the Hospitei within 24 hours a To the Funsrai I completely filled	Medical		hysician: To the best miner: On the basis of and manner s	of examina						
	To the P within 2- To the P complet	Σ	29b. Signature and title of certifier	2.			29c. Licens	se number		29d. Date signed (A	fonth, Day, Year)
			An 16	<u> </u>	MD		Kes	-000	/	November	30, 2006
			30. Name and address of person who	completed cause of	death (Item	n 23a) (Type Orth	Wolfe	Street	Bal	timore, 1	30,2006 UD 2128
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 1 4 2006	32. Regist	rar's Sign	orth ture					

06-09237

lans Green	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death	
Physician/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	-(
Medical Examiner	Hans Joseph Green 4b. City, Town, or Location of Death 4c. County of Death	_
January L	Anne Arundel Medical Center Annapolis Anne Arundel	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or Foreign	٦
Director	484-92-6357 1X M 2 F 42 Yrs Midnitis Days Hours Nov. 30,1964 Country Towa	_
any	10a. State 10b County 10c. City, Town or Location 10d Inside City Limits	ı
Maryland 28a-f show d at once. ector	Virginia Fairfax Alexandria 1 Yes 2 X No	,
ith the Maryland 23a or 28a-f sho notified at once. al Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5212 Franconia Road 22310 U.S.A.	
ms 23a be noti	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,	\dashv
er death with t	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	
hours afte hours afte Examiner ted by	3 Widowed 4 X Divorced of Yes, Give Year or Dates. 1 Yes 2 X No specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	
5-0036 ed within 72 hour hour hour hour than "natu he Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	
215-0036 be filed within 72 intal Hygiene. riked other interes of the Medical ent, the Medical Be Comple	2 carpenter construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	\dashv
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Roy Edward Green Joyce Joann Engelking	
MD 21 d 2 should dth and Me n 27 is ma aumatic ev	19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Husak, brother in law 308 Q St., NW, Washington, DC 20001	1
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 20c. Location - City or Town, State	7
Baltimore, pernit. Pages I an Department of Hea Important: If itee Important: If itee	4 Donation 5 Other Specify: Metropolitan Crematory 12/9/2006 Alexandria, VA	
Balti permit. Departm Imports injury o	22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt Harmony Lane Owings MD 20736	
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Approximate Interval Between Onset and Approximate Interval Between Onset and Approximate Interval Approxi	
/Medical Examiner	Immediate Cause (Final disease a Carbon Monoxide Intoxication	\Box
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
niner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
ted Insit Examiner	events resulting in death) Last Due to (or as a consequence of).	7
'60, rate be execut ohysician and re burial - tra	UNPENDED AMENDED	┨
Division of Vital Records, P.O. Box 68760, To the Hispital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1	┨
Box 687 death certific the attending p ed for use as th hysician//	230. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify)	
). Box 687 the death certification by the attending packed for use as the Physician/	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death?	4
Division of Vital Records, P.O. B tal or Attending Physician: The law requires that the d as after death al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached ertification: To Be Completed by Phy	1 Yes 2 No 3 Probably 4 Unknown	
Records, The law requires freate has been sign page 2 should be Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of	,
Reco The law icate has page 2 s	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
Vital Rec ysician: The his certificate: director, page o Be Con	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other:	4
of Virding Physical After this funeral dir	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	-
IVISION or Attendir after death Director: A I in by the fu	1 Natural 5 Pending Dec 4, 2006 0000 hrs 1 Yes 2 No Subject inhaled exhaust fumes	
Division o spital or Attending tours after death find al Director: Affiled in by the function:	3 V Suicide 6 Could not be determined (Specify) Single Family 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1187 River Bay Rd., Annapolis, Md.	
Division To the Haspital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	4 Homicide (Specify) Single Family (T187 River Bay Rd., Annapolis, Md. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated	1
To the Hrawithin 24 P To the Fur completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signatule and title of pertyler 29d Date signed (Month, Day Year)	_
	29b. Signature and title officertifier 29c License number 29d Date signed (Month, Day, Year) December 5, 2006	
	30. Name and address of person who cumpleted deutse of deat (Item 23a)	-
2	Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	4
State Registrar		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year December 07, 2006 Physician 3:40 A.M. Irma Getson /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Lonaconing Allegany Egle Nursing Home 5. Social Security Number Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF Days Months Hours Yrs. Director March 16, 1919 214-16-2767 Usual Residence of Decedent

10c. City, Town or Location

10d. Inside City Limits

1 Yes 2 No

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

10a. State

ģ

10b. County

oortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0020

Physician /Medica Examine

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

용	Maryland Alles	gany	Lonaconing						AQ Yes 2∐ No	
ē	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?		
aD	57 Jack	son Street			21539			U.S.A.		
ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J,S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Specify Yes or No	- 14. Rac	ce - American In	dian,	
교	1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2 X No	Specify:	to nicari, etc.)		ck, White, etc.		
<u>a</u>	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 1 10s 2 jag 110	эрвспу.		Specify	y: W	/hite	
Be Completed by Funeral Directo	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of wo	orking	16b. Kind of Business/Industry			
ם	Elementary/Secondary (0-12)	College (1-4or 5+)			a) urses Aide			Hospital		
ပြီ	12 17. Father's Name (First, Middle, Last)	0		INI		me (First, Middle,	Maiden Suman			
Be		William Cataon			10. Motifor 5 Ptd		Mary Nicol			
2	19a. Informant's Name/Relationship (T	William Getson	19h	Mailing Address (Street	and Number or E				(a)	
1			190.			Lonaconing,			θ)	
	Darlene Winter 20a. Method of Disposition		Place of	Disposition (Name of	ont street, i	Date Date	-	City or Town, S	State	
	1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	cemetery	r, crematory or other plac	'	December				
	4 □ Donation 5 □ Other (Specify,			Oak Hill Cemeter	•	11, 2006	Lonac	coning, Ma	aryland	
	21. Signature of Funeral Service Licens	see ·		22. Name and Addre	ineral Hom	Home P.A.				
L	Ina [/hken			8	East Main	Street Lona	coning, MI	O 21539		
	23a. Prit Enter the disease, or composition of k, or heart failure. List only of	lications that caused the dea one cause on each line.	th. Do n	ot enter the mode of dyir	ig, such as cardia	c or respiratory a	rrest,	Inter	roximate rval Between et and Death	
ı	Immediate Cause (Final disease or condition	a. Multi I	2-1	and De	20 p. 45			4	Years	
١	resulting in death)	a. Due to (or as a c	onsequence of):	mence					
ne.										
a I	Sequentially list conditions,	Due to (or as a c	unsequence of):						
ũ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
by Physiclan/Medical Examiner	that initiated events resulting in death) Last	Due to (c	or as a co	onsequence of):						
Z e		d								
an		u								
sic	Part II. Other significant conditions co	ntributing to death but not res	sulting in	the underlying cause giv	en in Part I.	23b. Did 1	tobacco use co	ntribute to the	cause of death?	
Æ	Stroka	Hypoto	- C1			1 🗆 1	Yes 2□ No	3 ☐ Probably	4 Unknown	
þ		Herra	0.30					T		
Be Completed	thyber list	Hy perto				24a. Was perfo	an autopsy rmed?	available	utopsy findings e prior to tion of cause	
瞳	101	Counts.						of death	?	
S						1 🗆 1	res 2 No	1 ☐ Yes	2 □ No	
Be	25. Was case referred to medical examiner?					ath (Check only o	ne)			
P	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Out	patient 3□ DOA Oth	er: 4 Nursing I	Home 5□ Resid	lence 6 □Oth	er (Specify)		
	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Ti	jury Wor		28d. Describe h	now injury occur	red		
cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No					
Medical Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		m, street, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural Rou	ite Number,	
a C	29a. Certifier TV Certifying Phy	sician: To the best of my kno	owledge.	death occurred at the tin	ne, date and place	e, and due to the	cause(s) and ma	anner as stated.		
dici	(Check only 2 Medical Exami	iner: On the basis of examina and manner stated.	ation and	or investigation, in my o	pinion, death occi	urred at the time,	date and place,	and due to the	cause(s)	
Me	29b. Signature and title of certifier	-, (29c. Licens	e number		29d. Date signe	d (Month, Day,	Year)	
	>	(Jemdh	~ H	D 1	4466	+	12.0	08-200	06	
1						F .				

48 TArn Terrace, thustburg, Maryland 21532

the completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar 31. Date filed (Month,

			1 - For Amend It	emStatepetrManyla	865 903 7 Cei	25/07d tificate	health and of Death		giene Reg. NG.	006	41098
	Physici		Decedent's Name (First, Middle, Last Helen Gloss	st)				2. Date of De Month Decemi	Day	Year 2006	3. Time of Death 8:38 P M
	/Medio Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Tov	vn, or Location of Dea			ounty of Death	0.30 F
			190 South Shore	Road		Swant	on		Gar	rett	
	Funeral Director	-15	5355-03-6786 6.S 355-03-1599	ex	s. last birthday) Yrs.	If Under 1 Y Months D	ear If Under 24 Hr ays Hours Mir		ıy, Year)	Coun	lace (State or Foreign try) inois
	pur M		Usuel Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				1	0d. Inside City Limits
	Maryla 1 • ho	5									1 X Yes 2 □ No
	r 28e-	Director	FL Saraso	ota i	Sarasot	10f. Zip Co	de		10g. Citize	n of What Coun	itry?
	th with	aiD	2440 Tulip Street			342	32		Uni	ted Sta	ates
	eme.	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent	of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No)- 14.	Race - Americ Black, White,	
36	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "netural," or items 23s or 28s-f show spiritury or other traumatic event. Its Medical Evantian trausities inclined at another.	by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	1 ☐ Yes 2 🖸				pecify: Whi	
21215-0036	2 hou	ted	15. Decedent's Ed	ducation	16a. Dece	dent's Usual O	ccupation		16b. Kind	of Business/Inc	
215	thin 7	Be Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	life.	kind of work a DO NOT use r	lone during most of w etired)	orking			
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and	be fill bd oth even	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,			
2	hould id Mei mark matic	은	Vasel 19a. Informant's Name/Relationship (Bokoff	19h Mailir	ng Address /Si	Mary treet and Number or F		Visnie er Civ or I		Codel
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ē,	s 1 er f Hee item other		20a. Method of Disposition	20b.	Place of Dispo	sition (Name	of	Date		tion - City or To	
Ë	Page nent o int: if	1 3	1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State //			Park /2	14-06	Saras	ota, FI	
Baitimore, Maryland	permit. Depertmitimports Imports eny inju		21. Signature of Juneral Service Licen					urdock-Di			
<u> </u>	8988		Gord A. Y) undock			21 N. S	econd St.	, 0ak		
	Pnysician		23a. Pand. Enter the disease, or com- spock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.							Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conse	equence of):	- HNC 61	1 wind	FIGHTOLA))		3 WEGKS
	Examiner	_	Sequentially list conditions, if any, leading to immediate	b							
	ted	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence on:						
<u>,</u>	icate be executed physiclen and s the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a conse	equence of):						
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99	ntifica ng ph s as th	Med	IF FEMALE:					700			
õ	ath ce	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregi	tal death 3	Ectopic pregr			230	Date of delive Month	ry Day Year
P.O. Box	Attending Physicien: The law requires that the death certificate be executed 'r death. 'r death. arter: After this certificate has been signed by the attending physicien and ector: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specif	ý)				,
٥.	s that ned by e deta	by Ph	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying caus	e given in Part I.	23e. Did t	obacco use	contribute to th	e cause of death?
rds	w requires that s been signed t should be det							10	Yes 2□N	No 3 ☐ Prob	ably 4 Unknown
900	law re as bee 2 sho	Completed						24a. Was		24b. Were autor	osy findings available
Œ.	The ete h	Com						perfo	med?	death?	2 No
/ita	cien: ertific ector,	Be	25. Was case referred to medical examiner?					eath (Check only o	one)		
5	Physi this o	7	1 ☐ Yes 2 ☑ No 27. Manner of Death		ER/Outpatien			Home 5 Resid			()
O	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28C.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	now injury o	ccurred	
Division of Vital Records,	Atten er deal	Certification:	3 Suicide 6 Could not be determined		home, farm, str			28f. Location (3 City or Tox		lumber or Rura	l Route Number,
<u> </u>	oital or urs afte rei Dir iled in										
	To the Hospital or Attending Physicien: The kawthin 24 burs after death. To the Funerel Director: After this certificele has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the vestigation, in	he time, date and place my opinion, death occ	ce, and due to the curred at the time,	cause(s) an date and pla	d manner as st ace, and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	/			cense number		29d. Date s	igned (Month, I	Day, Year)
			Culd	, MI)	1	51564		DEC	EMBOT	19,2006
		11	30. Name and address of person who		em 23a) (Type,	Print)	4 TM SF				
		4	1HOQ ZAKA 31. Date filed (Month, Day, Year)	32. Registrar's Sign		55 N	417 55	282 W	AKLAI	NO MI	71550
	Sta Registr		DEC 11	2006 2006	A	Americk 1	7				

Exa The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death.

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral

Director

/land ow at		10a. State 10	0b. County		10c. City,	Town	or Location						10d. Inside City Limits	
Mary Ffsh fied	to	Maryland F	rederio	ek	Walk	ters	sville						1A Yes 2 No	
r 28a r noti	irec	10e. Street and Number					10f. Zip C	Code			10g. Cit	izen of What C	ountry?	
h with	al D	9828 Dubli	in Road				2	2179	3			USA		
deat	Funeral Director	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.		13. Was Deceder	ent of His fy Cuban	panic Origin? (\$, Mexican, Pue	Specify Yes or Norto Rican, etc.))-	14. Race - Ame Black, Whi		
after or ite	/Fu	1 Never Married		1 TYPes 2 □ N		_	1 ☐ Yes 2		Specify:			Specify:	White	
ours Iral", IExa	d by	3 ☐ Widowed 4 [Year or Dates:	/iet N		S d d l l.	0			105 1	and of Overlanes	II male cations	
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uld b Menta arked	ဥ	Arno1d			Gouge				Eva			McKenny		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name					Mailing Address (8 28 Dubli							
s 1 al f Hea item othe		20a. Method of Dispos			20b. Pla	ace of I	Disposition (Name crematory or oth	e of her place)	Date	20c. Location - City or Town, State			
Page ent o nt: If ry or		1 X∑X Burial 2 □0 4 □ Donation 5		Removal from State			y Bapt. (9/2006	Mt. Airy, MD			
mit.		21. Signature of Fund	ral Service Lice	ensee			1				uneral Home, PA			
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Physician		Immediate Cause (Fir		nplications that caused cause on each li									Approximate Interval Between Onset and Death	
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Examiner				10	t	7	molon	200	0	home	0	Ligt	12h-	
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The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transi	Completed by Physician/Medical	_		_			the didentying out						Probably 4 □Unknown	
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nding Fith. : After e funera	tion:	27. Manner of Death 1. Natural 2 Accident	5 ☐ Pending investigati	28a. Date of Inju (Month, Da on			jury M	Bc. Injury Work' 1 ⊟ Y	es 2∐No	28d. Describe	now mju	ary occurred		
I or Atter after dea Director	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	d Zoe. Flace Utilij	jury - At hor tc. (Specify,		m, street, factory,	office		28f. Location City or To			Rural Route Number,	
To the Hospital or Attending Physicial within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical C			Physician: To the best aminer: On the basis of and manner st	of examinati									
o the	Me	29b. Signature and tij	tle of certifier				29c.	License	number		29d. D	ate sign e d (Mor	nth, Day, Year)	
Tinh		The state of the s	3	4	Cm	2	10	14	626		0	ec 6	, 2006	
101/11		30. Name and address	ss of person wh	o completed cause of o		23a) (1	Type, Print)	200	1	7636		2	2170/ 2170/	
1				v (-7036	-		- ,)	-		, ,		real	c-26/ 11/1	

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

DEC 1 1 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Gene Hahn December 6, 2006 8:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4309 Frankfort Drive Rockville Montgomery 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F Director 212-94-3968 90 Nov. 16, 1916 Korea Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notifled at 1 ☐ Yes 2 No Completed by Funeral Director Maryland | Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be USA 4309 Frankfort Drive 20853 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify 3 Nidowed 4 Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Chef permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Hahn Unknown ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Young Hahn/ Son 4309 Frankfort Drive, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State December 8 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. nchen 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Metastatic Lung Cancer resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Urisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 1∐ Yes 2K No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 1 [XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Milliams DD

State Registrar

Records, P.O. Box 68760,

or Vital

Division

DHMH 17 Rev 1/2001

(Darke

6001 Muncaster Mill Road, Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Cynthia Williams, D.O.

31. Date filed (Month Day, Year)

			1 - For State Registrar		-		/land / D	epartr		lealth	and M	lental Hy		006	and the second	01
	Dhysisi		1. Decedent's Name (First, Midd	ile, Last)								2. Date of Dea Month	ith Day	Year	3. Time of	Death
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	Examir		4a. Facility Name (If not institution	on, give	street and nu	ım <i>ber)</i>			City, Town, o		of Death			ounty of Deat		
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	Funeral		5. Social Security Number	6. Sex	(]M 2.[XF		n yrs. last birth		nths Days	If Under Hours	Min.	8. Date of Birth (Month, Day Nov. 8,	n /, Year)	9. Birt	nplace (State o untry)	or Foreign
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			Chronic Obst		tive L	ung D	isease					1 ☐ Yes	2⊠ No	1 ☐ Yes	2□ No	
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DIVISION	death. ctor: A y the fu	fica	3 Suicide 6 Could	not be	28e. Plac	e of Injury -	At home, farr					28f. Location (S	treet and	Number or Ru	ral Route Num	ber.
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To lating H	within 24 hours after death To the Funeral Director: completely filled in by the t	aic	29a. Certifier 12 Certify	ing Phys	sician: To th	e best of m	y knowledge,	death occ	urred at the tir	me, date ar	nd place, a	and due to the d	ause(s) ar	nd manner as	stated.	
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			Man	0	En	Uu	love	2	D018	52			Dec.	6, 20	06	
)	(1)		30. Name and address of person	n who co	mpleted cau	se of death	(Item 23a) (T	ype, Print						J, 20		
	9		Paul A. DeVo	ore,					Rd. Hy	attsv	ville	, MD. 2	0781			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day MARTON JORDAN HIINT 5:50A M DECEMBER 8,2006 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days 1 M 2 XF 94 072-09-0208 February 4, 1912 New York Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1. Yes 2 No Frederick Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 USA 1421 Taney Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No white Specify. Specify 3 AWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0'Shea Patrick Jordan Marie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Clark -Daughter 5615 Denton Court, Frederick, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State St. Mary of the Lake 12-12-2006 Lakewood, New Jersey 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Ligensee Maron anille Level 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preuwonia resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Dav 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? orgestive heart failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Funeral

Director

show r 28a-f show notified at

ms 23a or

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traumatic event,

permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Examine

Physician/Medical

Completed by

Be

P

Certification:

25. Was case referred to medical examiner?

1 ☐ Yes

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

2No

and -trar physician an s the burial-tr attending properties of the second se the detached ρλ has certificate

Records, P.O. Box 68760.

or Vital Physician:

Division

this within 24 hours after usa...

To the Funeral Director: After thir

To the Hospital or Attending Medical

State Registrar

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

autopsy

1□ Yes

Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) DEC 1 1 2006

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H			ZUUD	41103
			Decedent's Name (First, Middle)	dle, Last)		71,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Reg. 2. Date of Death		3. Time of Death
	Physici /Medic		Lorraine	V. Harris				Month December	4, 2006	6:47 P M
	Examin		4a. Facility Name (If not institution				Location of Death		4c. County of Death	
				Medical Cent		Annapol:			Anne Ar	
	Funeral Director		5. Social Security Number 232-32-3368	1 - C - C - C	e (In yrs. last birthday, '8 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 12/12/192	ar) 9. Birth Cou West	place (State or Foreign Intry) Virginia
	pu &		Usual Residence of Decedent 10a. State 10b. Count	N.	10c. City, Town or L	ocation				10d. Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene ther than "natural", or Iteme 23a or 28a-f ehow ant, tha Madical Evanthar must be notified a	ō		Arundel		gewater				1 Yes 2 No
	r 28a-	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
	th with	aiD	36 Virginia Av	venue		21037			USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specin, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Amer Black, White	
36	rs afte	y Fu	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	irried 1 ☐ Yes 2 1111	10	1 ☐ Yes 2 🛣 No	Specify:			White
9	2 hour	Completed by	15. Decede	ent's Education	16a. Dece	edent's Usual Occupa	ation	16b	. Kind of Business/li	ndustry
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Maryland 21215-0036	ntal H ed oth	Be	17. Father's Name (First, Middle	y Coffman			18. Mother's Name	(First, Middle, Maid al Gregor		
Ž	hould of Mer mark matic	은	19a. Informant's Name/Relation		19h Maili	ing Address (Street a	and Number or Rural			n Code)
S	nd 2 s lith an 27 is r trau		Diane J. Seman			-	ve., Edgev			<i>D</i> 00000)
altimore,	ss 1 a of Hea Item		20a. Method of Disposition	a 3 □Removal from State	20b. Place of Disponentary, cre	osition (Name of matory or other plac	e)		Location - City or T	
Ē	Page ment ant: It		14 □Donation 5 □ Other (Specify)	Kalas C	rematory	12-6-0		dgewater,	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department: It Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show any joilary or other traumatic event. It a Madical Examinating must be notified as once.		21. Signature 1 Mineral Service	e Livensee			ss of Facility Geo Mons Islar			
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caused st only one cause on each lir	the death. Do not en	ter the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate tnterval Between
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9	ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy			-	224 B-144-1	
Вох	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
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Records,	The law requires that the ate has been signed by the bage 2 should be detache	Completed						24a. Was an autopsy performed	prior to co	ppsy findings available impletion of cause of
_	sician: The law s certificate has l irector, page 2 s	e Co	OF Man annual second to madin	-1				1 ☐ Yes 2 2		2 🗆 No
Vita	Physician: r this certifica ral director, I	0 B	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital: Inpatie	nt 2 ER/Outpatie	nt 3 DOA Cthe	26. Place of Death		6 ☐ Other (Speci	6/1
סר	ding Phy h. After thi funeral	T:u	27. Manner of Death	28a. Date of Injur	y 28b. Time o		at 28	Bd. Describe how in		<i>y</i> /
200	endin eath. or: Af he fur	atic		tigation	injury		res 2 □ No			
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	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical (29a. Certifier (Check only one) Certify 2 Medica	ing Physician: To the best of il Examiner: On the basis of and manner sta	examination and/or in	h occurred at the tim vestigation, in my op	e, date and place, ar pinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as s and place, and due t	stated. to the cause(s)
	To the within To the comp	W	29b. Signature and title of certifi	er		29c. License	number	29d. [Date signed (Month)	Day, Year)
			1 11-1	/ MC)	DS	518 t	1	2/4/	6
	6		30. Name and address of person	Ta	eath (Item 23a) (Type,	Print	Arunde	Med	dical (enler
4	Sta Registr	-	31. Date filed (Month, Day, Year DEC 0	6 2006 32 Aegistra	ur's Signature	od .				

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		Registrar		Cei	unca	ite of Death	2. Date of Dea	leg. No.	3. Time of Death
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Examir	ner	4a. Facility Name (If not institution, give s Southern Maryland				y, Town, or Location of Deat linton	n	4c. County of	Death e Georges
Funeral Director			7. Age (In yrs.		If Und Month	der 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day July 31	, 1919 S	Birthplace (State or Foreign Country) with Caroling
anyland •how	2	Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1- 1- 1- Yes 2 □ No
th the M or 28a-f	Funeral Directo	Maryland Prince Ge	orges For	estvil	1	Žip Code	1	10g. Citizen of Wha	10
Ih wi	1 2	7803 Berry Place			2	20747		United S	tates
d within 72 hours after death with the Maryland siene. r than "natural", or Items 23a or 28a-f ehow the Modeal Examinar rust be notified at	by Fune	11, Marital Status 1 □ Never Married 2 □ Married 3 ☼ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerl 2番No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc.
72 hours at natural, or		15. Decedent's Educ	Year or Dates:	16a. Dece	dent's U	sual Occupation	rkina	16b. Kind of Busin	Black ness/Industry
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新 古 子 語	To Be Co	17. Father's Name (First, Middle, Last) Andrew Hamer		Juni	01		me (First, Middle, e McBride	Maiden Surname)	
2 sh and te m	F	19a. Informant's Name/Relationship (Type Geraldine Morgan/Da				ess (Street and Number or Au y Place; Fore			ate, Zip Code)
1 and Heelth tem 27	-	20a. Method of Disposition	20b. P	lace of Disno	sition /A	Jame of	Date	20c. Location - Cit	
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ital or Attending is efter death. ral Director: Afte	Certification:	3 Surcide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	(y)			City or Tow	n, State)	or Rural Route Number,
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- (5)		30. Name and address of person who co	4, MD	South	Print)	00064055 Musland	H.)	pital Co	Me
St Regist	ate	31. Date liled (Month, Day, Year)	32. Registrar's Signa	iture					

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Funeral Director				7. Age (In yrs. Ia		If Under 1 Year Months Day		n.		eign
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212	o Be	19a Informant's Name/Relationship			19b. Mailing	Address (Stree			mber, City or Town, Sta	ate, Zip Code)
MD and 2 short the and a 2 is saumatic		Ruth Smith (Mo	ther)		1			Shady	Side, Md	20764
		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal fro		lace of Dispos	ition (Name of ce		Date	20c. Location - City Davidso	
Baltimore, permit Pages I an Department of Her Important: If ite	Ц	4 Donation 5 Other Spec	cify:	Mei		Garde		7-06	.1	nville, MC nville, Md
Ball permit Depart Impor		21. Signature of Funeral Service Lie		407					uary, P.	
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Box 6876(death certificate the attending phy ed for use as the b	sicia	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregna	ant at time of dea		her (Specify)				,
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1041	ate	Ana Rubio MD. Assis 31 Date filed (Month, Day, Year)	tant Medical E	nstrar's Signatur		ueet, Baitimi	ore, MD 2120			
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			For State Registrar	State of Mary		artment of H		, ,	ne No 2 () ()	6 6110	16
	District		Decedent's Name (First, Middle,	Last)				2. Date of Death Month		3. Time of Dea	ith .
	Physic /Medi		LINDA			KELSE		DECEMBER	,	006 14:35	М
	Exami	ner	4a. Facility Name (If not institution, g	give street and number) Hみたいぐら Hc	COTAL	BALTIN	Location of Death		4c. County of	f Death	
	Funeral	_		. Sex 7. Age (In	yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Fo	reian
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow erry injury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ↑ Year or Dates:	in U.S. 13.		spanic Origin? (Spen n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		American Indian, White, etc. White	
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Baltimore, Maryland 21215-0036	Pages 1 a nent of Hei nt: If Item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	□Removal from State Re	ob. Place of Disposes Enaven	osition (Name of majory or other place Memorial	Gardens I	ec. 18,	:. Location - C 2006]	ity or Town, State Frederick, N	1D.
Balti	permit. Departn Imports eny inju		21. Signature of Funeral Service Lice	1. Barber	M00021		nd Basford			- MD 21701	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause onedaci line.	PS/S				ederic	Approximate Interval Between Onset and Death	1
30,78	*	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conductor) Die to (or as a conductor) Die to (or as a conductor)	rsequence of):	MELLIT	US	<u>Y</u>		2 YEARS 46 YEAR	25
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.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3[Ectopic pregnancy Other (specify)			23d. Date of Month		
rds, P.	w requires that the de been signed by the a should be detached f	Ď	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause give	n in Part I.	23e. Did tobaco	\ /	ute to the cause of death ☐ Probably 4 ☐Unkno	
al Records,	sician: The law re certificate has bee rector, page 2 sho	Completed						24a. Was an autopsy performed	prio dea	ore autopsy findings available to completion of cause ath? I Yes 2 □ No	able of
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Division of Vital	al or Atter de la Directe de la by ti	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)	eet, factory, office	28	8f. Location (Street City or Town, St		or Rural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, s	Medical C	29a. Certifier (Check only one) 1 Certifying I	Physician: To the best of my aminer: On the basis of exam and manner stated.	knowledge, death nination and/or in	n occurred at the time vestigation, in my op	e, date and place, ar inion, death occurre	nd due to the cause d at the time, date	e(s) and mann and place, and	er as stated. d due to the cause(s)	
}	To the Comp	×	29b. Signature and title of certifier	AR, MEDICAL 6	201700	29c. License	number			Month, Day, Year)	
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	30			THE JOHNS H	OPKINS 1	HOSPITAL, 6	00 NOATH	WAFE STAR	ET. BALT		3
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Samuel Edward Kydd, Sr. Preido 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months 1 ☑ M 2 ☐ F 81 Yrs December 13,1924 West Virginia 232-50-6083 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Prince Georges Lanham 1 X Yes 2 □ No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20706 United States 3324 Hayes Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 2 No 1943 If Yes, Give Year or Dates: 1946 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Marshall George Kydd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Kydd/Spouse 3324 Hayes Street; Lanham, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐Removal from State Metropolitan Crematory12/6/2006 Alexander, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike; Forestville, Md. 21. Signature of Funeral Se 20747 23a. Part1. Enter the dis_ase, or/ mplic tio s that caused the shock, or heart fall are. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Fina disease or condition resulting in death) to (or as a consequence 1) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ue to (or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not respiting in In underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 Unknown Mb. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician certificate this After 1 death

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Physician

/Medical

Examiner

Director

Funeral

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Completed

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Certification: To

Medical

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

72 hours after

should be fi and Mental F

and !

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once.

Physician /Medical

Samule/E Baltimore, Maryland 21215-0036

Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

State Registrar 29b. Signature ar

and manner stated.

29c. License number

Suite 351 Lowel MO. 20707

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of per so who completed cause of Yearh (Item 23a) (Type, Print)

Mond main Strut

Day, Year)

4 ☐ Homicide

29a. Certifier (Check only one)

32. Registrar's Signature

06-09606	
Russ Korz	

Russ Korz	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2 1 1 5 4 4	10
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 1. Decedent's Name (First, Middle,Last)	h
wedicar Examine	Ross David Korz December 16, 2006 1633 nrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	Shady Grove Hospital Rockville Montgomery	
Funeral Director	5. Social Security Number 212-84-3311 6. Sex 1/1 X M 2 F 7. Age (In yrs. last birthday) 46 Yrs. Months Days Hours Min. June 24, 1960 Foreign Greens D.	
aus	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City	Limits
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ath with the Maryland itens 23a or 28a-f show any st be notified at once.		
한 호텔 급	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc.	ζ,
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Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examinier. To Be Completed by F	Henry Kurz Estelle Cass	
ID 21 2 should and Me 27 is ma matic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co2088 19846 Billings Court, Montgomery Village, Md.	6
re, N s I and S f Health If item	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 XBurial 2 Cremation 3 Removal from State crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	
Baltimor permit. Pages Department of Important: If	4 Donation 5 Other Specify: Judean Mem. Gdns 12/19/2006 Olney, Maryland	
	21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Edward Sage1 Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20	
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Trazadone intoxication Approximate I Between Ons Death	
Examiner	or condition resulting in death) Due to (or as a consequence of):	
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Sion Attendi death sctor: by the f	Pending Investigation Fnd 12/18/2006 Fnd 3:30 pm 1 Yes 2 X No unknown	
Division c spiral or Attending nours after death neral Director: Affilled in by the fun Certification	3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 19846 Billings Court (Specify) residence 28f. Location (Street and Number or Rural Route Number of Town, State) 19846 Billings Court (Specify) Village, MD	r, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ex		
T To S To S	and manner stated. 29b. Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year)	
	Maryine The Your O.C.M.E. December 17, 2006	
	30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State	31. Date filed (Month, Day Year) 2006 31 Registrar's Signature	-
Registra	DEG TO COOK MANAGEMENT TO THE	

			1 - For State Registrar	State of	Maryla	nd / Depa <i>Cei</i>	artmen rtificat			ınd M	ental H	ygien Reg. No	200	6	41109
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			2536 Bayview Rd.				Gir	dlet	ree			W	orcest	ter	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Margaret Kina 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner University
5. Social Security Number Baltimore 8. Date of Birth (Month, Day, Year) of Maryland Wedical Cent If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** Hours Days 1 □ M 2 🗓 F Maryland 214-36-4611 66 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6047 Melbourne Avenue 20751 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □ Yes 2X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mone. College (1-4or 5+) Administrative Assistant Aircraft Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Burdette Estelle Duva11 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard T. King - Husband 6047 Melbourne Avenue, Deale, Maryland 20751 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematorium 12/10/06 Alexandria, Virginia 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service Lisensee Molesworth-Williams P.A., Funeral Home X-26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Phorus /Medical Examiner hyperralemia 24 hours Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner The law requires that the death certificate be executed Metestatic Lung Cancer physician and s the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed Division or Vital 2 No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Hnpatient 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: filled in by the funeral after death Director: within 24 hours a To the Funeral I the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P21162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Baltimere, MD 2120 31. Date filed (Month, Day, Year)

State Registrar

Medical

DEC 1 1 2006

			1 - For State Ragistrar	State of N	Maryland / [artmen rtificate				-	giene Reg. No.	06	41111
	Physici /Medi		1. Decedent's Name <i>(First, Middle, Last,</i> Kenneth Lewis	Keller							2. Date of De Month Decemb	Day	2006	3. Time of Death 4:00 A M
	Examir		4a. Facility Name (If not institution, give Moran Manor Nurs		or)		•		Location of				y of Death	
	Funeral Director		210 10 0070	7 ≹M 2□F	Age (In yrs. last bir 87	thday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da July 3	th 1919	9. Birthi Cour Mary	place (State or Foreign ontry) rland
	e Maryland 3a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD. Allegany	7	10c. City, Town		cation port	·					1	0d. Inside City Limits 127€es 2 □ No
	th with th		10e. Street and Number 313 Spruce S	St.			10f. Zip	^{Code} 215	62			10g. Citizen of United		•
9036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show solical Examiner must be netified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ➡ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 Dyes 2 If Yes, Give Year or Dates	s? ∃ ^{No} WW 2	1	Was Deced f Yes, spec		panic Origin, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	14. Ra Bla Specii	ce - Americ ick, White, fy: Whi	etc.
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hc It of Health and Mental Hygiene. If Item 27 Is marked other than "nature or other traumatic event, the Medical	Completed	15. Decedent's Edu (Specify only highest grad. Elementary/Secondary (0-12) unknown	cation e <i>completed)</i> College (1-4a		Deced (Give life. L	tent's Usua kind of wor DO NOT us Foren	k done di e retired) Ian	uring most				Manuf	acturer
yland	2 should be file and Mental Hy Is markad oth raumatic event	To Be (17. Father's Name (First, Middle, Last) James Rober]	Ethe:	l Stub			
, Mar	and 2 sh ealth and m 27 Is m		19a. Informant's Name/Relationship (Ty Judith Biser/ nied		85	Ch.	estnu	ıt St		este	mport,	er, City or Town Maryla		Code) 21562
Baltimore,	permit. Pages 1 and 2 Department of Health i Important: If item 27 I any injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ R `4 □ Donation 5 □ Other (Specify)			y, cren OS C	emete	her place LY		12/ 200		20c. Location Western		Maryland
Bal	permit Depar Impor any in		21. Signature of Funeral Service License	Bor	l	1		urch	st.	, Wes	sternpo	ral Hom rt, Mar		21562
ı	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caus ne cause on each	ed the death. Do reline.	not ente	Perm	of dying	, such as	cardiac o	r respiratory ar	rest, ds to		Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dua to (or a	is a consequence of	οľ).								
P.O. Box 6	death certif e attending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		e of pregnancy 2 Fetal death at time of death		Ectopic pre Other (spe						ite of delive	ory Day Year
	The law requires that the de ate has been signed by the a page 2 should be detached f	þ	Part II. Other significant conditions con	tributing to death	but not resulting in	the un	derlying ca	-				obacco use cont		e cause of death?
Division of Vital Records,	n: The law r icate has bo r, page 2 sh	Completed			·						24a. Was a autop perfor 1 Yes	med?	prior to con death?	osy findings available inpletion of cause of
of Vit	Physician: r this certifica ral director, I	To Be	1 105 2/2140	ospital: 1 ☐ Inpa				Other	4/Ziaur	sing Hom		ence 6 🗆 Oth)
sion (landing Feath.	Certification:	27. Manner of Death Natural 5 Pending Accident investigation 3 Suicide 6 Could not be	28a. Date of In (Month, D	ay Year) Ir	njury	М		at/ es 2□N		8d. Describe h	ow injury occur.	red	
Σ	To the Hospital or Attanding Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		4 Homicide determined	building,	njury - At home, far etc. <i>(Specify)</i>						City or Tow	n, State)		Route Number,
	he Hosp in 24 hou he Fune pletely fi	edical	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examination	ician: To the bes er: On the basis and manners	or examination and	, death dor inv	occurred a estigation,	t the time in my opii	, date and nion, deatl	l place, a h occurre	nd due to the o d at the time, o	ause(s) and ma late and place,	anner as sta and due to	ated. the cause(s)
	Tot withi Tot	M	29b. Signature and title of certifier					License	number	44	_	29d. Date signed		Day, Year)
	VA	5	30. Name and address of person who co Dr. Jesus Tan. 4		death (Item 23a) (215	32			1011		
	Sta Registr	_	31. Date filed (Month, Day, Year)		trar's Signature		ands)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 0 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year December 8, 2006 **Physician** Mary Loretta Kroll 1:15 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Westernport Moran Manor Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 6, 1922 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 212 F 84 218-16-3527 Yrs. Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28e-f show any injury or other traumatic event, Ire Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County MD. Allegany Westernport XXYes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 Poplar St. 21562 United States 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 ☐No Specify: Š 3∰Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Retail College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Darr Flora Pearl Henry ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 Morrison St., Westernport, Maryland 21562 Barbara Fisher/ friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12/11/ 1 Burial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) Westernport Maryland Philos Cemetery 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home - Wac 111 Church St., Westernport, Maryland 21562 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Swere Physician Antic disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and d for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. It yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) ed by the a detached f signed by to Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ere bro vasculos Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably ► ☐ Unknown been signature should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 No 1 ☐ Yes 2 ☐ No certificate 1 Yes To the Hospital or Attending Physician: : After this certification and director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Specify) 1 ☐ Yes 2 →No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending s after decreal Director: Alte 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide thin 24 hours after de the Funeral Director mpletely filled in by th 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11/2 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/11/06 921244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21532 Dr. Jesus Tan, 4 Broadway, Frostburg, MD.

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 11:00 РМ December Patricia W. Lang /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville 202 South Hilltop Rd. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 3/10/1936 1 □ M 2 🔀 F Maryland 219 26 6088 70 Director Usual Residence of Decedent death with the Maryland 10d, Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 1 ☐ Yes 2 No Director Catonsville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 202 South Hilltop Rd. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Wunder Mae Emma Litz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Catonsville, MD 21228 19a. Informant's Name/Relationship (Type. Print) 202 South Hilltop Rd. Milton Lang, Jr./husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory 12/7/2006 Catonsville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M0144221. Signature of Funeral Service Licensee 4112 Old Columbia Pk. Ellicott City, MD 21043 Approximate Interval Between Onset and Death 2 3 475 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** on oncev /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initioal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as for use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No detached 9 Unknown 9 Unknown à. Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Tes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2X No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2**X** No 2 ER/Outpatient 3 DOA 1 Inpatient ို this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or A 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific \$18587

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State Registrar

DEC 0 5 2000

31. Date filed (Month, Day,

30. Name and address of parson who completed cause of death (Item 23a) (Tyge, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day
December 2, **Physician** Ruth Ellen. Lynagh 10:33 a M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 21X F 1951 Director 220-60-3274 55 Sept. Mary Tand Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show Maryland Montgomery Olney 1 ☐ Yes 2 No Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Experiment be a 20832 USA 17408 Blossom View Drive by Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ∐ Yes 2 ∐MyNo If Yes. Give 1 ☐ Never Married 2 T Married Baltimore, Maryland 21215-0036 Special hite 1 ☐ Yes 2 ☐xNo Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital/Medical Administrative Aide othe 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental marked Robert Langford McKay Ruth Arlene Phillips traumatic ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17408 Blossom View Drive, Olney, Maryland 20832 James J. Lynagh, III/Husband Item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State December 7, 4 Donation 5 Bother (Specify) entombment Gate of Heaven Cemetery 2006 Silver Spring, Maryland Francis Addess Collyins Funeral Home Inc. le. 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cardiovascular Pulmonary Arrest Minutes /Medical Due to (or as a consequence of): Examiner Acute Myocardial Infarction Minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 5 signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Colon Cancer 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate 1 Yes 28 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □XYes 2 □ No ၉ 2 X ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1x Natural 5 Pending death. 1 Tes 2 No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title a certifier 29c. License number 29d. Date signed (Month, Day, Year) Med Orred and December 7, 2006 D0050410 MGH e Mrek 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Philip Drive, Olney, MD 20832 M) 18101 31. Date filed (Month DEC 32. Fegistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006 8

S. College

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené UU b Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1 2 Month 04^{Day} **Physician** 2006 05:55 Michael A. Leonard A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Fort Washington Hospital Fort Washington Prince George's 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Sociat Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) 1 🔀 M 2 🗆 F 579-80-9784 Yrs. 03/01/1971 Director DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or Items 23a or 28e-f show the Medical Examinar must be notified at 1 Yes 2 □ No Directo Prince George's Temple Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 #303 USA 3458 Brinkley Road death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 21X Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "nat any injury or other treumatic event, the Mazica once. Elementary/Secondary (0-12) Coltege (1-4or 5+) Maintenance Technician Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nolan Reed Evelyn Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3458 Brinkley Road #303 19a. Informant's Name/Relationship (Type, Print) Monique Leonard / Wife Temple Hill, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National * 4 ☐ Donation 5 ☐ Other (Specify) 12/09/2006 Suitland, MD 21. Signature of Funerat Service Licensee 22. Name and Address of Facility 3831 Georgia Avenue, NW Ralph Washington, DC 20011 Latney's Funeral Home Mams 23a. Part1. Enter the disease, or comptications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) Ad mocardial Priysician /Medical Due to (or as a consequence of) **Examiner** unet Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit 2 porto been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Due to (or se consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 has certificate 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 PR/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After tniury 1 PNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitel or At within 24 hours after of To the Funerel Direct 4 - Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified P Daly 00053117 01 30. Name and address of person who complet a cause of death (Item 23a) (Type, Print) stor Rd, Fof Wester

Registrar DHMH 17 Rev 1/200

State

31. Date filed (Month, Day, Year)

11711 L WW

MD

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 27 at 28 af Maryland (L.D. e8 at men) 21 / 15 and Mental Hygiene 23 a Pti, II Certificate of Death Reg. No. 2 1 - For State Registrar Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Mary Linney 1:49 P^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, April 28 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1923 Mitchellville MD Months 1 ☐ M 2 🖼 F 83 577-28-0202 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits show ral", or Items 23a or 28a-f shov Examiner must be notified at 1, Yes 2 No Director MD Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3942 23rd Parkway #12 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify. à Specify lack 3₺ Widowed 4 Divorced Year or Dates "natural", Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Cook Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Countiss Mary Thomas ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Kelly /Granddaughter 4002 23rd Parkway #22 Temple Hills of Health 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Resurrection Cemetery 12-6-2006 Clinton MD 4 Donation 5 Dother (Specify) of Funeral Service Licer 22. Name and Address of FacilitPope Funeral Home 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-trar attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760 The law requires that the death certificate be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23h Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) Ö 2 No be detached 9 Unknown signed by ئم Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Left Hip Fracture 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autonsy perform Chronic Renal Disease this certificate 1∏ Yes 21 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month. Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After Injury 191 5 Pending investigation teral 11/24/2006 **Unknown**^M 1 Yes Subject fell after death 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Nursing Home 920 Stuart Lane, Clinton, MD within 24 hours a Pertifying P ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exp miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) ho completed 30. Name and addre cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, D

32. Registrar's Signature

		1	For State	State of Maryland	•	artment of He			giene Reg. No. 2006	41117
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ıth	3. Time of Death
	Physicia		William A. Mers	son				12/11	/2006	7:10 A ^M
)	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Town, or	Location of Dea		4c. County of Dear	
			1421 Taney Avenue	Apt 520		Frederic			Frederick	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Day	y, Year) 9. Bird	hplace (State or Foreign nuntry)
	Director	-	213-28-2010 Usual Residence of Decedent	76	115.			1/19/19	930	MD
	land w		10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits
	Man)	ţō	MD Frederic	ck Fre	ederi	ck				1 XYes 2 No
	n 198	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	23a	a D	1421 Taney Ave	Apt 520		21702			USA	
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (n. Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
36	within 72 hours after deeth with the Maryland ene. then "netural", or Items 23e or 28e-f show he Medical Exercit et mast be notified at	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □ Yes 2√2 No	Specify:		Specify:	Thai to a
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7. 10.	in 72 n n	plet	(Specify only highest grad		(Give	kind of work done di DO NOT use retired)	uring most of w	orking		
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פ	be filed itel Hygi od other event, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Sumame)	
<u>Ja</u>	should b ind Ment marked umatice	2	William A. Merson				Goldie			
Maryland	2 shc and In m		19a. Informant's Name/Relationship (7						or, City or Town, State,	
2 6	1 and Health em 27 ther tr		Hilda M. Merson 20a. Method of Disposition			Taney Ave		Date Prede	erick, MD 2 20c. Location - City or	
altimore,	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at 2006.		1 → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		sition (Name of natory or other place	1			
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	Physician	9	shock, or heart failure. List only of Immediate Cause (Final		ement	ia				Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequer		,14				
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87	physicate t	Physician/Medical		d		-				
9 x	death certific e ettending pl id for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance					23d. Date of de	livery
Вох	Jeath etter	clar	in the past 12 months?	1 Live birth 2 ☐ Fetel de 4 Pregnant at time of deat		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.		hys	9 Unknown	9□ Unknown						
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rd	w require been sig should b	ed						1 🗆 1	/es 2 □ No 3 □ P	robably 4 ∐Unknown
of Vital Records,	as b	Completed						24a. Was	an 24b. Were a	utopsy findings available completion of cause of
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/ita	Physician: The this certificete ral director, pag	Be (25. Was case referred to medical examiner?			100		eath (Check only o	ne)	
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isi	Attending r death. ector: After by the fune	Icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		e. farm. st				Street and Number or F	ura I Route Number,
Division	l or Atten efter deat Director:	Certification:	4 Homicide determined	building, etc. (Specify)	.,,			City or Tov	vn, State)	
	Hospitel 24 hours e Funeral letely filled	a	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowle	edge, deat	h occurred at the tim	e, date and pla	ce, and due to the	cause(s) and manner a	s stated.
	To the Hospitel or Attending Phwithin 24 hours effer death. To the Funeral Director: After the completely filled in by the funeral	edical	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	n and/or in	vestigation, in my op	oinion, death oc			
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	-1		29c. License	number		29d. Date signed (Mon	th, Day, Year)
				, , , _	mp	D 531	129		12/11/20	06
	10		30. Name and address of person who				1	M 1 1	21702	
		ate	Dr. Dale Heitzig 31. Date filed (Month, Day, Year)				erick,	naryland	21/03	
	Regist		DEC 2 6 2		A	ande)				
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DHMH 17 Rev 1/2001

ORIGINAL

06-09588	
Mary Martin	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day December 15, 2006 Medical Examiner Mary Martin 2213 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min. September 01, Foreign Washington 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 578-42-1083 Days Director 2XXF M 81 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits XX Yes 2 No Maryland Prince George's notified at once. Temple Hills within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country 2707 Iverson Street 20784 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian, Black, or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc 1 Never Married 2 Married 2 X No Yes 3 XXWidowed Specify: Black Divorced If Yes. Give Year Yes 2 XXNo specify: <u>م</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene
If item 27 is marked other than "
ther traumatic event, the Medical Baltimore, MD 21215-0036 Twe1th Cook Unknown 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Unknown Be Louise Shelton 19a. Informant's Name/Relationship (Type, Print) ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other traumatic Eileen Martin-Daughter 2707 Iverson Street Temple Hills MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State permit Page
Department o
Important: Riverdale Crematory 12-21-06 Riverdale Maryland Donation 5 Other Specify: 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Sign Jule of Funeral Softvice Licenses 1661 Good Hope Rd SE, Wash DC 20020 23a, Part I. Enter the disease, or com lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Hyrertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical physician a the burial - 1 X UNPENDED **AMENDED** #23a,27,perME. Box 68760. IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy 2 Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ₽ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? page 2 After this certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: 26 Place of Death (Check only one Be Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural 5 Pending r death Director: d in by the f Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 Could not be Suicide or Town, State determined 4 Homicide 29a Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License numbei 29d. Date signed (Month. Day, Year) O.C.M.E December 16, 2006 30. Name and a sess of person w o completed cause of death (Item 23a)

State

31. Date filed (Month, Day, Ye DEC 2 0 2006

Pamela E. Southall, MD Assistant Medical Examiner

32. Registrar's Signature

Registrar

111 Penn Street, Baltimore, MD 21201

			For State Registrar		State of	Marylai		artmen rtificat				lental Hy	giene 2 Reg. No.	2006		120
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			Howard Cour 5. Social Security Number	ty Ge			oital . last birthday)		umb:	l a If Under	24 Hrs.	8. Date of Bir		ward	lace (State o	or Foreign
	Funeral Director		229-37-131	1 1	M 2□F		3.2 Yrs.	Months	Days	Hours	Min.	(Month, Da	iy, Year)	74 Vir	try)	_
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	how		10a. State 10b. Co	unty		10c. C	ity, Town or Lo	ocation						1	0d. Inside Ci	ity Limits
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	with the	Dir	10e. Street and Number	a M.	77. D.			10f. Zip						n of What Cour	try?	
	filed within 72 hours after deeth with the Maryland Hygiene. yther then "naturel", or Iteme 23a or 28a-f ehow yet, the Medical Examinar must be notified at	by Funeral Director	7331 Oaklar		LLS KC				046	spanic Or	igin? (Sp	ecify Yes or No	US.	A. Race - Americ	an Indian,	
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Z.	should ind Men in marke umatic	-	19a. Informant's Name/Rela							and Numb	er or Rur	al Route Numb	er, City or 1	Γοwπ, State, Zip		
	s 1 and 2 should be filed within 72 hours after deeth with the Marylar if Health and Mantal Hygiene. Item 27 is marked other then "naturel", or Iteme 23a or 28a-1 ehow then traumatic event, the Medical Examinar must be notified at		Tamara Tucl	cer-M	orris/	Wife	7331	. Oak	lan	d Mi	11s	Rd.#1	02,C	olumbi	a,MD2	1046
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Baltimore,	permit. Pages 'Department of H Importent: If ite any injury or ot		21. Signature of Funeral Se			/								1 Home ria, V		
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.O. Box 6	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	11		th 2 Feat	tal death 3[⊒Ectopic p ⊒ Other (s¢					23	d. Date of delive	-	Year
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/ita	Physicien: Tribis certificateral director, pr	Be	25. Was case referred to m examiner?	-	i conital:		VT15		0#		e of Deat	h (Check only	one)			
of	Physical distriction	2	1 Yes 2 No				28b. Time d			4 🗆 N	ursing Ho	ome 5 Res		Other (Specif	1)	
o	Afte	tion	1 PNatural 5 □ F	ending vestigation	28a. Date of (Month)	, Day Year)	Injury	м	28c. Injun Worl 1 □	k? Yes 2 🗀]No	200. 20001120	now injury	00041104		
Division of Vital	il or Attending efter death. I Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ C	ould not be etermined	28e. Place o	of Injury - At g, etc. (Spec	home, farm, st	reet, factor	y, office				(Street and wn, State)	Number or Rura	i Route Num	ıber,
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		1	> 500 v	and)	& Ke	em	$oldsymbol{L}$	1	723	60	1		Nou	30	200	6
^	R(10)	/			ompleted cause	of death (Ite	эт 23а) (Турө	Print)	, 1	D/			1 1	30, 4,MD		
			E. LEE, Mb 31. Date filed (Month, Day,	1	065	Little	e l'at	uxe	IT I	new	41	Colu	MDic	1,MD	2104	15
	St Regist	ate rar	DEC 0 7 20		Belle >	B. A	perk									

State Registrar Widhi Singh 31. Date filed (Month, Day Year

DEC 07

9901 Medical Center Drive, Rockerlle, MO

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Physician
/Medical
Examiner

Funeral Director

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparement of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or items 23a or 28s-f show any injury or other traumatic event, the Marylical Examinar coust be notified at once.

MAKY A. MADDOOX

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: Atter this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

•	1 - State Registrar	State of Maryland /	-	nent of H cate of D		Mental Hygien	2006	41122
n al	1. Decedent's Name (First, Middle, Last) MARY Ar	no MAD				12 07		3. Time of Death 0843 M
r	4a. Facility Name (If not institution, give s Peninsula Region 5. Social Security Number 6. Sex	nal Medical Cen 7. Age (In yrs. last b	her inthday) If L	Sal Inder 1 Year	Sbury If Under 24 Hr	8. Date of Birth	C. County of Deal Wicomi 9. Bird	C () thplace (State or Foreign
	Usual Residence of Decedent	M 21XF 83	Yrs.	nths Days	Hours Min	(Month, Day, Year 10-05-1923	Co	MD
ector	10a, State 10b. County Some	eset Pri	n <i>cES</i> S	An	15			10d. Inside City Limits 1 ☑ 4es 2 ☐ No
ral Dir	30380 MAPIE	ST.		of, Zip Code			U.S.A	
d by Fune	11. Marital Status 1 Never Married 2 Married 3 StVidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:		es 2 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Black, Whit	
Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade	cation 16: 9 completed) College (1-4or 5+)	(Give kind of life. DO No	Usual Occupa of work done d OT use retired,	uring most of we	orking 16b. I	Kind of Business Cook	
To Be C	17. Father's Name (First, Middle, Last) CharLES Nixon				18. Mother's Na MARY	me (First, Middle, Maide Newcon		
	19a. Informant's Name/Relationship (Ty) Charles Maddon	90, Print) 19 - Son 2		dress (Street a		Nural Route Number, City 1:15/010, DE		
	20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State cemet	armol	corother place	9 12-	13-2004 Pri	ncess An	ng MD
	21. Signalura Funeral Service License	Pard Sk.				nthony E. Wa - Princess Ar		21853
	23a. Aart1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do e cause on each line. Due to (or as a consequence	ASPIRA		NEVMON	•		Approximate Interval Between Onset and Death ONE WEME
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence		PULMO	NARY	EMBOLISM		UNC WEEK
edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):	A.	sin			THAR
Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		pic pregnancy er (specify)		8	23d. Date of del Month	livery Day Year
ed by Pr	Part II. Other significant conditions con	tributing to death but not resulting	in the underly	ving cause give	n in Part I.			o the cause of death?
Complete						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 X Inpatient 2 ☐ ER/C	utactiont 2	DOA Othe	ar-	eath (Check only one)	C COther (Co-	-4.1
ation: I	27. Manner of Death 1 Matural 5 Pending 2 Accident Investigation		Time of Injury	28c. Injury Work		Home 5 Residence 28d. Describe how inju		Oily)
Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, fa	actory, office		28f. Location (Street a City or Town, Star	and Number or Ru te)	ural Route Number,
Medical Certification; To	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occu nd/or investig	ation, in my op	inion, death occ	urred at the time, date ar	nd place, and due	e to the cause(s)
Σ	29b. Signature and title of certifier		56	29c. License			ate signed (Mont	
	24	DR-USHA M	1250M	Dr	51359	D1	cember	7/5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

MO 21804

SALISBURY

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. DIVISION

DEC 1 2 2006

1415. 31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Marylar			t of Hea e of De		Reg	ene 1. No 2 0 0 6	41123
	Physic /Medi Examii	cal	Norma Jean Aa. Facility Name (If not institution, give Laurel Region	Miles e street and number)			Town, or Local	D ation of Death	2. Date of Death Month ecember	Day Year 6,2006 4c. County of Dea Prince	12:00A ^M
	Funeral Director		5. Social Security Number 6. S 578-52-6447 Usual Residence of Decedent	ex 7. Age (In yrs. □ M 2☐ F 6.		If Under Months		Jnder 24 Hrs. ours Min. Fe	8. Date of Birth (Month, Day, Y	^{9. Bi} 20,1941	rthplace (State Dereign Country) Washingto
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show mixprincts of other traumatic event, the Modical Examinar must be notified at page.	Funeral Director	MD Montg 10e. Street and Number 3205 Wood Ave	omery I	ty, Town or Lo	svil			10g	g. Citizen of What C	10d. Inside City Limits 1 □ Yes ② No Country?
9036	ours after des ral', or items	þ	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Deced f Yes, spec 1 ☐ Yes		nic Origin? (Sp exican, Puerto pecify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	od within 72 h giene. er than "natu , the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0·12)		(Give	kind of wor DO NOT us	n Decupation of done during se retired)	g most of work	ing 16	b. Kind of Business	s/industry Home
Maryland	should be filed with nd Mental Hygiene. marked other that umatic event, the	To Be	17. Father's Name (First, Middle, Last) Leo Rawlings	Supp. Ovint)	105 14-15			Mari	e (First, Middle, Ma	iden Sumame) ngs	
	s 1 and 2 sho i Heelth and item 27 ie my other traumy		19a. Informant's Name/Relationship (1) Dawn Griffin/I 20a. Method of Disposition	Daughter 206.F	3205 Place of Disposemetery, crem	Woo	d Ave	. Bur	tonsvil	City or Town, State, Le, MD 20 c. Location - City or)866
Baltimore,	permit. Pages Department of Important: If it any injury or o		1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	see A D MOO	nity 1945 Å	Memo REHA	rial KT-EC	HOLS 1	FUNERAL	HOME, P.	A.
pro-	Physician /Medical Examiner	her	23a. Part1. Enter the disease, or composition shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) 5 agus itially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	aDue to (or as a conseq	monia _{uence of):} Stage			Scle		riaca,r.	Approximate Interval Between Onset and Death
8760,	ate be executed obysicien and the burial-transit	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq d.	uence of);						25
P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pro				23d. Date of de Month	olivery Day Year
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Z:E	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1X Inpatient 2	50:0		Othor	200	Check only one		
of	ding h. After fune	atlon: To	27. Manner of Death 11 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Bc. Injury at Work?		me 5 Residence 28d. Describe how	e 6 □Other (Spe injury occurred	ecify)
Division	P Har	Certification;	3 Suicide 6 Could not be determined	building, etc. (Specif	y) 				City or Town, S	State)	ural Route Number,
	Hospital 24 hours a Funeral I	Medical	29a. Certifier T Certifying Phy (Check only one)	ysician: To the best of my kno inter: On the basis of examina and manner stated.	iwledge, death tion and/or inv	occurred a restigation,	at the time, da in my opinion	ate and place, a n, death occurr	and due to the caus ed at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
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9	33		30. Name and address of person who of Shahab Bavani	,MD 10724 L	ittle	Drint)				mbia,MD	21044
1	Sta Registi		31. Date filed (Month, Day, Year)	32. Rifgistrar's Signa		rack					

		•	State of Maryland / Department State of Maryland / Department State Certificate	it of Health and Me te of Death	ental Hygien	2006	41124
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
_ [Physicia /Medic		Robert E. Mccullough	1	Month D December	7 2006	10:20A M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City,	Town, or Location of Death	4	c. County of Death	
			Berlin Nursing & Rehabilitation Ber			orceste	
	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthday</i>) If Under 2.1.9—1.9—0.9.0.0 1		B. Date of Birth (Month, Day, Yea	r) Cou	olace (State or Foreign ntry)
	Director		218-18-0890 XXX SI Yrs.		9 14 1	925 MD	
	land ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Many -1 eh	ठ्	Worcester OceanCity				1□Yes 2□No
	2 should be filed within 72 hours after death with the Maryland and Mental hygiene. ie marked other then "natural", or Itema 23a or 28a-f show sumatic event, the Medical Examinar must be rediffied at	Funeral Director		Code	_	Citizen of What Cou	ntry?
	23a c	la		1842		USA	
	tems	nue	V Amed Forces? If Yes, spe	dent of Hispanic Origin? (Spec scify Cuban, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Ameri Black, White,	
36	', or I	by F	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No Navy 1 ☑ Yes 3 □ Widowed 4 □ Divorced Year or Dates:	2□ No Specify:		Specify.Whi	te
gh, Robert Maryland 21215-0036	2 hou		15. Decedent's Education 16a. Decedent's Usu	al Occupation	16b.	Kind of Business/Ir	
75	hin 72	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) (Give kind of wo	ork done during most of working use retired)			
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g g	al Hy d oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	an Sumame)	
Ro Va	Mental Merked of atto eve	2	Earl Jennings McCullough	Evelyn F			
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cculloud Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 ie marked eny injury or other traumatic ev 9000.			William St.	Burbag Berlin		
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	certii nding use a	/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	ery
ă	death e ette	iclai	in the past 12 months? 1 Vec. 2 No. 2 No. 4 Pregnant at time of death 5 Other (s)			Month	Day Year
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ē	F 8 F C	Certification:	4 ☐ Homicide Getermined building, etc. (Specify)		City of Town, Sta	110)	
	To the Hospital or Attending Physicien: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only (Ch	d at the time, date and place, a n, in my opinion, death occurre	nd due to the cause id at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
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	T W I	1	1754	028769		1-1-6	
			30 Note and address of person who completed cause of death (Item 23a) (Type, Print)			1~1010	70
E	AIOTI		Welco Bordules (D 1209 Co	restel testimo	a Fewie	to Telan	26 1, Oe 19741
	St	ate			1		1
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			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H		_	giene	06 41125
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*	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat		oer 4,20	U6
	LAdimii	E1	Manor Care Potom			Po	tomac		Montg	omery
	Funeral Director		5/9-46-1292	7. Age	e (In yrs. last birthday 97 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan. 20	th ly, Year) 0,1909	9. Birthplace (State or Foreign Country) Germany
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation	-			10d. Inside City Limits
	a-fsh	tor	MD Montgome	ry	Potomac					1⊠Yes 2□No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	
	a 23a	rai	10714 Potomac Ten		Superior II C 12	Was Deceded at H	20854	Pagitu Vas or No	United	States e - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23e or 28a-f show amy injury or other traumatic event, Ite Medical Exerting must be multiple at any injury.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	No 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	Specify:	to Rican, etc.)	Blac	ck, White, etc. White
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Maryland 21215-0036	d 2 shoul th and Me ?7 is marl traumati	Ė	19a. Informant's Name/Relationship (7			ing Address (Street			versi venso i	
	s 1 an of Heal Item 2		Becky B. Parker/ 20a. Method of Disposition		20b. Place of Disp cemetery, cre	Bellingt osition (Name of amatory or other place		Date	20c. Location -	City or Town, State
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Baltimore,	permit. Departr Imports any inj		21. Signature of Frieral Service Licen	Buga		2. Name and Addre				ons Inc. , DC 20016
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<u> </u>	that the	/ Ph)	Part II. Other significant conditions c	ontributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco use conf	tribute to the cause of death?
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of <	Physician: r this certific ral director,	To	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 🗌 Inpatie			4 Ja Nursing I	Home 5 Res	idence 6 Oth	ner (Specify)
o uc	ding After	ion:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b. Time Injury	Wor	yat k? Yes 2 □ No	28d. Describe	how injury occur	red
Division	or Attenditer death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	ury · At home, larm, s c. (Specify)				(Street and Numb own, State)	ber or Rural Route Number.
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C								anner as stated. and due to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	28		29c. Licens				ed (Month, Day, Year)
	1.		· As			Doos	54566		12/5	106
	10		30. Name and address of person who							
			SUN Tha Bhoga	VIKI, 12L	O A Earl T	uppa Aca	d, such 2	30 TOCC	NOW, M	D 21286.
	Sta Regist	ate rar	31. Date liled (Month Day, Year)	006	ar's Signature	perti				

/N To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Medic	al	Charles	J.	Moor	adlan			Decemb	er	7 , 2006	10:05	р
amin		4a. Facility Name (If not institution	on, give street and n	umber)		4b. City, Town, or	Location of [Death	4	c. County of Dea	th	
		6285 Stephen	Reid Ro	ad		Hu	ntingt	own		Cal	vert	
****		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthdav)	If Under 1 Year	If Under 24	Hrs. 8 Date of Bi	rlh	I 9 Bir	thplace (State or I	Foreian
eral		•	1 ∑ M 2□F	83	Yrs.	Months Days	Hours	Min (Month, D	ay Yea	(2) CC	ountry)	
ctor		005-16-9531		0.3				Van. 4	132	3 Ma:	ıne	
	ŀ	Usual Residence of Decedent		100 0	ty, Town or Lo	nation					10d Incide City	Limito
any injury or other traumatic event, the Medical Examiner must be notified at		10a. State 10b. Count	у	100. 01	ly, TOWITOTEC	Cation					10d. Inside City	
2	후	MD Cal	vert	Hı	intingt	own					1 🗌 Yes 2	∑ X No
	Director	10e. Street and Number				10f. Zip Code			10a. C	Citizen of What Co	ountry?	
3	ا ۵					· ·	0		_		-	
ISI	Funeral	6285 Stephen R	eid Road			2063				United S		
	ne	11. Marital Status	12. Was De Armed F	cedent Ever in U	.S. 13.	Was Decedent of H	ispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Ame Black, Whit		
		1 ☐ Never Married 2X Ma	rried 1X Yes	2 □ No 19	343 <u>—</u> I			3310 (11041, 510.)				
	þ	3 ☐ Widowed 4 ☐ Divorce	d If Yes, C	ilve	946	1 ☐ Yes 2 🙀 No	Specify:			Specify:	White	
	B	15 Decede	nt's Education		16a. Dece	dent's Usual Occup	ation		16b.	Kind of Business	/Industry	
	Completed		est grade completed	1)	(Give	kind of work done of DO NOT use retired	during most o	f working	100.	Tana or Basinoso,	and don'y	
	면	Elementary/Secondary (0-12)	College	(1-4or 5+)		_			_ ا			_
	Ö			+	OCE	eanograph	er		I∈	ederal go	overnmen	τ
	Be (17. Father's Name (First, Middle	, Last)				18. Mother's	Name (First, Middle	e, Maide	en Surname)		
	B	Robert Zakar	Mooradia	n			Ouee:	nie Taq	ui	Kalamia	an	
	2	19a. Informant's Name/Relation			401 11 7	111 (2)						
				G				or Rural Route Num.				
		Arlean Iris Mo	oradian,	Spouse	6285	Stephen .	кета к	oad, Hunt	Ing	LOWIT, IND	20037	
		20a. Method of Disposition		I .	Place of Dispo	sition (Name of matory or other plac	20)	Date	20c.	Location - City or	Town, State	
		1 ☐ Burial 2 X Cremation	3 ☐Removal from	n State			1	40.00.00			T 778	
	ļ	4 □ Donation 15 □ Other (Met				12-09-06	ALE	exandria	, VA	
-	_	21. Signature of Funeral Service	Licensee			2. Name and Addres	,					
-		Fato	1 all		I	Rausch Fu	neral	Home, P.A	. Ov	vings, M	D 20736	
		23a. Part1. Enter the disease, of	or complications that	t caused the deat					-		Approximate	-
		shock, or heart failure. Lis	st only one cause on	each line.	\sim		3,	,			Interval Betwee	een eath
n	ļ	Immediate Cause (Final disease or condition	2	CAP								
ıl	1	resulting in death)	Due to	o (or as a consec	uence of):						50,00	-0
r											3000	
	-	Sequentially list conditions,	b. — Duo t	o (or as a consec	ulonco of):						1000	wy
	ine	cause. Enter Underlying	2 Due 1	o (oi as a consec	delice oi).							
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. [Discussion of the cause] that initiated events	С.									
	EX	resulting in death) Last	Due to	o (or as a consec	quence of):							
ı	gi		d			-					-	
	hysician/Medical	IF FEMALE:										
	Z	23b. Was decedent pregnant		outcome pf pregn birth 2 Feta		∃Ectopic pregnancy	,			23d. Date of de		
	Ci.	in the past 12 months? 1 ☐ Yes 2 🔼 No		gnant at time of		Other (specify)				Month	Day Ye	ear
	ys	9 Unknown	9□Unl	nown								
	Ph	Part II. Other significant condit	tione contribution to	death but not see	culting in the	nderlying eaves ein	on in Dart I	220 Did	tobacce	use contribute to	n the cause of dos	ath?
	þ	wat in Other significant condit		o I	AA	indenting cause give	on in Fail I.			_ \		
		11/095	<u> </u>	MM	grew	Love		1	Yes	2 □ No 3 P	robably 4 □Un	ıknown
	Completed	Comm	amn - 1		1	\sim 1 \sim		24a. Wa	s an	24h Were a	utopsy findings av	vailable
	d	- COSUN	NIVY O	NOTO	18 X Y V	+ dr	seas	aut	opsy	prior to	completion of cau	use of
	Ö		O		(\mathcal{I}		1 Yes	ormed?	death? No 1 ∐Yes	No No	
		25. Was case referred to medic	al				26. Place of	f Death (Check only	-	•		
	Be	examiner? 1 ☐ Yes 2 No	Hospital:	Titit OF	ER/Outpatier	oth	or.	1/				
	မ		1		· · · · · · · · · · · · · · · · · · ·	IL SU DOA	4 🗀 Nursi			6 □Other (Spe	есіту)	
	Certification:	27. Manner of Death 1 Natural 5 ☐ Pend	/A 4	e of Injury onth, Day Year)	28b. Time o	f 28c. Injur Worl	y at k?	28d. Describe	now in	jury occurred		
	i E		tigation			M 1	Yes 2 ☐ No	·				
	<u>9</u>	3 ☐ Suicide 6 ☐ Could	mined 286. Pla	ce of injury - At h	ome, farm, sti	eet, factory, office				and Number or Ri	ural Route Numbe	er,
	높	4 ☐ Homicide deter	bui bui	lding, etc. (Speci	fy)			City or To	own, Sta	ite)		
								1).				
	cal		ing Physician: To t al Examiner: On the									
	Medical	one)		anner stated.	AND AND UN	roonganon, in my o	Pilioli, ucalli	Source at the tille	, uale à	ara piace, ario du	o to the cause(s)	
	Me	29b. Signature and title of certifi	ier			29c. Licens	e number		29d. D	Date signed (Mont	th, Day, Year)	
			10-10	2 ~ 1 1		DA	027	12a		2.8.0		
		· Jaw		LOVY			1 - 1		· ·	۵. ۵ ،	200 6	
		30. Name and address of perso	n who mpleted ca	use of death (Fer	m 23a) (Type,	Print)						
		30. Name and address of perso	n who impleted ca				land a	d Humi	Ma-	NINO MA	200=	30
Sta		30. Name and address of perso Zohir Youso 31. Date filed (Month, Day Year)	f, m.D.		solon		land R	2d. Hunti	ngh	own, mi	0 2063	39

			For State Registrar	State of	Marylan	id / Depa <i>Cei</i>	artment of F tificate of	lealth ai <i>Death</i>	nd Me		giene2	106	41127
	Di		1. Decedent's Name (First, Middle						2	Date of Dea	ith Day	Year	3. Time of Death
	Physicia /Medic		ECHA M	ARIA	M	AGU	RE		(^ -		006	11=47A M
	Examin		4a. Facility Name (If not institution,	-			4b. City, Town, o				4c. Count		
			HARROND ME				HAJE	26 Or	42	ACE	НА	ero	
	Funeral		5. Social Security Number 214-70-8577	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours	Min. T	Month Ca)	Y9940	9. Birth Cou Gern	place (State or Foreign ntry) 1371 x
	Director		Usual Residence of Decedent		66	113.				. 0.0 • 1.0 1	1310	CCLI	activ
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Man	to	MD Harf	ord		Aberde	en						1 ŽYes 2 ☐ No
	r 28s	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	ntry?
	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23a or 28a-f ehow he Madical Examiner must be notified at		144 Brannan Ro	ad			210	01			U.S.	Α	
	dea	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13. \	Was Decedent of H	lispanic Origi an. Mexican.	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	14. Ra	ce - Ameri	can Indian,
92	or It		1 Never Married 2 Marrie		2 No		I ☐ Yes 2 No			, ,		'n Whi	
~ 8	hours uref.	d by	3 Widowed 4 Divorced		ites:	1 100 D	teetle Heart Comm						
15	n 72	lete	15. Decedent (Specify only highes			(Give	lent's Usual Occup kind of work done DO NOT use retire	ation during most (d)	of working	,	16b. Kind of E	susiness/in	idustry
1147	withi iene. ther	Completed	Elementary/Secondary (0-12) 12	College (1-	-4or 5+)		emaker				In H	ome	
	Hygie other	0	17. Father's Name (First, Middle, L	ast)				18. Mother	's Name (First, Middle.	Maiden Suma	me)	
6 <u>a</u>	Aenta Aenta rked tlc ev	To B											
(to o c	2 should and Men le marke eumatic		19a. Informant's Name/Relationsh				g Address (Street						o Code)
~ Z	and 2 salth n 27 I		Glenn C. Magui	re, Sr. (S			Brannan				Maryla	nd 2	21001
1 2 J	of He of He or oth		20a. Method of Disposition	3 □Removal from 5	20b. F	Place of Dispo cemetery, crem	sition (Name of natory or other pla emorial	CB)	12/20	0/06	20c. Location		
<u>Ē</u>	Pag ment ant: I		4 Donation 5 Other (Sp		Har			j			berdee	n, Ma	ryland
$i z/t_{\rm b}/\sigma_{\rm b}$ Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 ie marked other then "neturel", or iteme 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be notified at ORCS.		21. Signature of Funeral Service	icensee Dys Un	Orles	be A	Name and Address arring-Caperdeen,	ess of Facility argo Fi Mary L	unera and	1 Home 21001-	33 ^P 9 ^A •		
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that ca	aused the deat	h. Do not ent	er the mode of dyi	ng, such as ca	ardiac or r	respiratory ari	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		1-1	ASC	15						Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as a conseq								
			Sequentially list conditions, if any, leading to immediate	b									
	led Islt	nine	rf any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a conseq	uence or):							
Mr.	cate be executed obysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (d	or as a conseq	uence of):							
8760,	bur čie												
9	ificate g phys as the	edic									1		
Fred Box	leath certifica ettending pt I for use as t	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna		Ectopic pregnanc				23d. Da	ate of deliv	ery
	deat	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☑ No		ant at time of d		Other (specify)	, 			M	onth	Day Year
mg.0.	at the	hy	9 Unknown										
	es the	þ	Part II. Other significant condition					_	- A 1-P				he cause of death?
Efra Records	w require been si should t	Completed	211 2112	5 45 0 51 No	14516	COR	14 - CA	520	こんらて	1 U Y	es 2□No	3∐ Proi	bably 4 Junknown
E C	law nes b	nple								24a. Was a autop	SV	prior to co	opsy findings available ompletion of cause of
		Con								perfor 1 ☐ Yes	med? 2⊠No	death? 1 ☐ Yes	2 1 No
رح) Vital	Physicien: The law r this certificete hes t iral director, page 2 s	Be	25. Was case referred to medical examiner?	Hansitali			l ou		of Death (Check only or	10)		
C-STREET,	Physical this d	P.	1 Ves 2 No 27. Manner of Death	Transport of the Control of the Cont		ER/Outpatien	I SLI DOA		-		ence 6 Ot		<i>fy</i>)
A Gu	Afte fune	둳	1 Natural 5 ☐ Pending	4	of Injury h, Day Year)	28b. Time of Injury	Wo	yat rk? Yes 2.∐N		d. Describe ii	ow injury occu	ii ea	
ma (I or Attending Phatter death. Director: After this in by the funeral.	fica	3 ☐ Suicide 6 ☐ Could n	ot be go Bleen	of Injury - At he	ome, farm, str	eet, factory, office	163 2010		f. Location (S	treet and Num	ber or Run	al Route Number,
Di V	after after Dire	Certification;	4 ☐ Homicide determi	buildir	ng, etc. (Specif	y)	001, 120101 y, 011100			City or Tow	n, State)		
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, i	Medical C	29a. Certifier 1 Certifying (Check only one)	g Physician: To the Examiner: On the ba and mann	sis of examina	owledge, death ation and/or in	occurred at the tivestigation, in my	me, date and opinion, death	place, an	d due to the o	cause(s) and m date and place,	anner as s and due t	stated. o the cause(s)
	o the	Me	29b. Signature and title of certifier	with the file	otalou.		29c. Licens	e number		2	29d. Date signi	ed (Month,	Day, Year)
	⊢ ≯ ⊢ ŏ		Gunna	>mh !		7.0	(i	2180	9		1) 8	Liz.	2006
			30. Name and address of person v	who completed caus	e of death (Iter	n 23a) (Tvne	Drine)				700	2	
	10		9.5.PRAR	HU MO		36	foak	0	1 1 6	4000	i DM	NO	21593
	Sta		31. Date filed (Month Par) Yaarin	2006 32 32	gistrar's Signa		ade					-	
	Registr	ar	201			0							

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

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			State of Maryland /	Departr		lealth and I	Mental Hy	_	6 41	129
		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		ne of Death
Physician		FLORENCE VIRGINIA	NAGLE				Month	Day	Year	60 AM
/Medica Examine		4a. Facility Name (If not institution, give st			4	lb. City, Town, or I		4c. County	of Death	
Examine	1	EGLE NURSING HOME 5		ET	LO	ONACONING	3	ALLEG	ANY	
Ermanal		5. Social Security Number 6. Sex	7. Age (In yrs. last t	oirthday) If	Under 1 Year	If Under 24 Hrs.			9. Birthplace (St Country)	ate or Foreign
Funeral Director			M 257 84	Yrs. Mo	onths Days	Hours Min.	3-21-1	y, Yea <i>r)</i> 922	Country) WISCONSI	V
	ŀ	Usual Residence of Decedent								
ylanc 30 W		10a. State 10b. County	10c. City, To	wn or Locatio	n				10d. Insid	de City Limits
Mar Mar	ĕ	MICHIGAN MACOMB	EASTP	OINTE					1₹	Yes 2 □ No
with the Maryland a or 28a-f show the notified at	<u>e</u>	10e. Street and Number		10	Of. Zip Code			10g. Citizen of	Vhat Country?	
be filed within 72 hours after death with the Maryland tal Hygiene. I other then "natural", or itema 23a or 28a-f show event, the Mcdical Examinar must be notified at	<u> </u>	15056 STEPHENS DRIV	⁷ E		48021			UNITED	STATES	
deat	ě	11. Marital Status	2. Was Decedent Ever in U,S. Armed Forces?	13. Was	Decadent of H	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No	- 14. Rac	e - American India	n,
or Re		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 📉 No If Yes, Give		res 21∑ No	Specify:	o i noan, oto.)		WHITE	
ours all, o	2	3XXVidowed 4 □ Divorced	Year or Dates:		- 2M140	эрвопу.		Speciij	WILLE	
"natural", edical Ex	Completed	15. Decedent's Educa (Specify only highest grede	ation 16	a. Decedent's	s Usual Occup	ation during most of wor f)	rkina	16b. Kind of B	usiness/Industry	
it e e it	<u></u>	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	IOT use retired	1)				
er than 1	5	12		ACCO	UNTING			RETA		
be filed withintal Hygiene.	2 C	17. Father's Name (First, Middle, Last)				18. Mother's Nar				
	<u>•</u>	DAVID McLELLAN				GLADYS S	STODDARD	MCLELL	AN	
s 1 and 2 should f Health and Mer tem 27 is marke other traumatic	Ų	19a. Informant's Name/Relationship (Typ				and Number or Ru				
1 and 3 Health em 27 other tr		JACQUELYNNE McLELLA				AVE. FRO)STBURG,			
permit. Pages 1 and Department of Health Importent: If Item 27 any Injury or other to once.		20a. Method of Disposition 1 □ Burial 2 □ X cremation 3 □ Re		of Disposition ery, cremetor	n (Name of ry or other plac	xe)	Date	20c. Location -	City or Town, Sta	te
Pages nent of int: If Its irry or o		4 □ Donation 5 □ Other (Specify)		RLAND	CREMATO	DRY 1	12-23-06	CUMBER	LAND MD	
permit. Pag Department Importent: II any Injury o	Ĭ	21. Signature of Funeral Service Licenses			me and Addres	-		60 U	MAIN ST	ס ביבייי
Depa Impo any Ir	1	Mas mo	moa547	SOW	ERS FUI	NERAL HON	ME, P.A.		BURG, MD	
	\dashv	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	15	o not enter the	e mode of dyin	g, such as cardiad	or respiratory a		Approx	imate
Physician	1	shock, or heart failure. List only one	cause on each line.							Between and Death
/Medical		Immediate Cause (Final	coreptu vascu	lar A	colde	rt			7 .11	1883
Examiner					- 4M-1- (-				1	
	<u>ē</u>		hyper tensive	e li Vel	11) 11/01	(N) 07 0	110004		5 Y	1ats
d ansit	Examiner		Due to (or as	a consequent	•	JVC/ U V	117, 7			
be executed sician and buriel-trensit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	500 (0) 40	a consequent	50 017.					
ysicia	i i	Cause (Disease or injury that initiated events	Due to (or as a	Consequenc	e of).					
		resulting in death) Last	200 10 (01 43 1	zoonocquone	, o oi,					
ndin use		4 d.							4	
The law requires that the death certifica site has been signed by the attending phyage 2 should be detached for use as the control of the state of t		Part II. Other significant conditions conti	fluting to death but not resulting	in the under	ving cause giv	en in Part I.	23b. Did 1	obacco use co	ntribute to the ca	use of death?
the cache	<u>~</u>	Tarin ettier eiginierit eenanete een	butting to doubt out that recomming	,	,g g		10	1	3 ☐ Probably	
that	침							7		
n sig							24a. Was	en autopsy	24b. Were auto available p	
shol	Completed		- 10.				peno	rmed?	completion of death?	of cause
The law ete hes page 2	Ĕ						101	Yes 2 No		2□ No
	2	25. Was case referred to medical				OC Diago of Dog			10.163	<u>-</u>
or Attending Physicien: after death. Director: After this certific in by the funeral director,	ng ng	overninos?	ospital:	D. 4 - 4 - 6 - 6	Oth	or:	ath (Check only o		(Cif-)	
Phys	<u></u>	27. Manyler of Death		. Time of	28c. Injur		lome 5 Resid	now injury occur		
After fune		1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury N		k? Yes 2 □ No				
deal deal ctor: y the	Ica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home,	farm, street,	factory, office		28f. Location (S	Street and Numb	er or Rural Route	Number,
or A effer Dire	Certification:	4 ☐ Homicide	building, etc. (Specify)	, ,	,		City or Tov	vn, State)		
ours eral filled		29a. Certifier 1 Certifying Physi	clan: To the best of my knowled	ne. death occ	urred at the tin	ne, date and place	and due to the	cause(s) and ma	nner as stated.	
Hos 24 h Fun etely	edicai		er: On the basis of examination a							ise(s)
To the Hospitel or Attending Pr within 24 hours efter death. To the Funeral Director: After the completely filled in by the funeral	Σ Σ	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe	d (Month, Day, Ye	ar)
F > F ŏ		Inancet Man	w.D.		00	9231		nicimho	r 19)	006
	-	On Name and address of	Motod cours of death (11 - 12 -	Vaca Prince		, , , ,		1100010	, ,	
U		30. Name and address of person who con	I U Q I I II -	(Type, Print	から	Cumb. M	0. 7 500			
		1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	32 Registrar's Signature	Angel		CN.1.), 1,1	n. di			
State Registra		31. Date filed (Month Day, Year) 200	b profession to	The state of the state of						

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760 %

		•	For State Registrar	State of Ma	arylan		rtment			ind Me		iene	06	41130
	Physicia	ın	Decedent's Name (First, Middle, Last)	Lorenz	o Ne	elson					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medica Examine		4a. Facility Name (If not institution, give s St. Mary's	treet and number)	- 110		4b. City, 1		Location o		De	4c. Coun	ty of Death	1
ı	Funeral Director		370-00-2030	M 2□F	e (In yrs. i	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Feb 11,), _{Year)} 1946	9. Birth Cou Was	place (State or Foreign intry) hington, D.C.
	Maryland -f show		Usual Residence of Decedent 10a. State 10b. County MD St. Ma	ry's	10c. City	y, Town or Loc	cation	Le	xington	Park				10d. Inside City Limits 1 ☐ Yes 2 No
	h with the	Funeral Director	10e. Street and Number 21688 Ranger Road		1		10f. Zip	Code	20653	3		l 0g. Citiz <i>e</i> n o	f What Cou	*
036	irs a	<u>م</u>	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	2. Was Decedent I Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:			Vas Deced Yes, spec		spanic Orig n, Mexican Specify:	jin? (Spec , Puerto P	cify Yes or No- lican, etc.)	Bt	ace - Amer ack, White ify: Black	
Baltimore, Maryland 21215-0036	within 72 ho iene. than "natur: Ine Musical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 10		i+)	16a. Deced (Give i life. D	ent's Usua kind of wor OO NOT us	k done d	<i>luring</i> most)	of workin	g	16b. Kind of	Business/li	·
land 2	ould be filed Mental Hygic arked other atic event, II	To Be C	17. Father's Name (First, Middle, Last)	ward Price Ne	elson				18. Mothe	r's Nam <i>e</i>	(First, Middle, Ethel	Maiden Suma Geneva I		
, Mary	is 1 and 2 should be of Health and Menta item 27 is marked other traumatic even		19a. Informant's Name/Relationship (Type Maria Louise Nelson/wife	pe, Print)		21688	Range	r Road	d Lexing		Route Numbe ark, MD 20	-	n, State, Zi	ip Code)
imore		ĺ	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		lace of Disposemetery, crematery,			i	12/09	9/06	20c. Location Lexi		own, State Park, MD
Balt	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service License	ewell			1451	ell Fu Dare	neral Ho es Beac	ome h Road	d Prince Fi		MD 206	78
•	Physician /Medical Examiner		23a. Part1. Enter the disease, or complicators, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused e cause on each lin Camc Due to (or as	10. er 1	Lary					arta			Approximate Interval Between Onset and Death
رم 68760,	ate be executed hysicien and the burial-transit	ical Examiner	Squentially list conflicts if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as										
(e/son) .0. Box 68	Physiclen: The law requires that the death certificat this certificete has been signed by the attending phy rail director, page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal	Ideath 3□	Ectopic pre						ate of delivership	uery Day Year
\mathcal{J} rds, P.	w requires that it been signed by should be detac	<u>م</u>	Part II. Other significant conditions con	tributing to death b	ut not resi	ulting in the un	nderlying ca	iuse give	en in Part I.		23e. Did to		-	the cause of death?
72.0 I Record	The law resete has been	Completed									24a. Was a autop perfor 1 ☐ Yes	SV	. Were aut prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
ピカソital	ysiclen: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	ospital:				Othe			(Check only or			
- 5	g e	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 X Inpatie 28a. Date of Inju (Month, Da		28b. Time of Injury		Bc. Injury Work	4 🗆 1401	2	ne 5 ☐ Resid 8d. Describe h			ify)
LC Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At ho c. (Specify	ome, farm, stre	eet, factory	office		2	8f. Location (S City or Tow		ber or Rui	ral Route Number,
	the Hospitel hin 24 hours it the Funerel upletely filled	edical	29a. Certifier Certifying Physical (Check only one)	ician: To the best er: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred a restigation,	at the tim in my op	e, date and pinion, deat	d place, a	nd due to the d d at the time, d	ause(s) and ri late and place	nanner as , and due	stated. to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier Cal	-9	~	1. D.	29c.		number + 3 4	- 6	i	9d. Date sign	` 4	
	5			ajja,	U.D.	tare -					Holly	wood,	MD	20636
	Stat Registra		31. Date filed (Month, Day, Year) DEC 6 2006	32. Registra	ar's Signa	ture of the second	ì							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMENU ITEM#Pt.II, 23e, perPHYS. G862, 12/22/06, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 4, 2006 Year Lec. 7:15 Αм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1747 Westmoreland Trail Annapolis Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours 219-28-6638 73 Director Nov. 28, 1933 Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Anne Arundel Annapolis in than "natural", or items 23a or 28a-f shape the Medical Examiner must be notified 1 ☐ Yes 2 X No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1747 Westmoreland Trail 21401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 □ No If Yes, Give Year or Dates: 1956–76 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Navy Federal Elementary/Secondary (0-12) Vice President Credit Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry A. Nichols Margaret Fleetwood ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tran Eleanor Nichols/wife 1747 Westmoreland Trail Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 12/6/2006 Baltimore, Maryland Funeral er ce Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any learning to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the sid be detached for or Vital Records, P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? nificant conditions contributing to death but not resulting in the underlying cause given in Part I. þ es 2 No 3 Probably 4 Munknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an has certificate 1□ Yes Exposure to asbestos 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 After this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral (27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of ce tifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestgate Road, Soite 303, Amapolis, Ph.II. MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 6 200b Registrar

			For State Registrar	State of N	Maryland / Dep Ce	artment of F			giene 006	41132
	Physici	an	1. Decedent's Name (First, Middl					2. Date of Dea	ath Nav Year	3. Time of Death
	/Medic	al	Wilda Hazel Or 4a. Facility Name (If not institution		r)	4b. City, Town, o	r Location of	Decembe	4c. County of Dea	th 130 AM
	Examin	er	St. Catherine			Emmitt		1004.17	Frederic	
	Funeral		5. Social Security Number		Age (In yrs. last birthday	If Under 1 Year Months Days	If Under 2	Min. (Month. Day	h 9. Bii	rthplace (State or Foreign ountry)
	Director		189-14-3033 Usual Residence of Decedent	1□M 2∏F	85 Yrs.			March 20	0, 1921 Pen	nsylvania
	ow ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	e-f sh	ctor	Maryland Fred	erick	Emmit	tsburg				1⊠Yes 2□No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	
	eath w	erai	331 S. Seton A	venue	at Ever in U.S. 13		21727	nin? (Specify Yes or No-	United St	
(0	r Itam	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Mar	ried Armed Forces				gin? (Specify Yes or No- , Puerto Rican, etc.)	Black, Whi	te, etc.
21215-0036	within 72 hours atter death with the Maryland ene. then "natural", or Itams 23e or 28e-f show te Madical Exertirer must be nutilised at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2 🔀 No			Specify: W	nite
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	e filed al Hygi I othar vant, II	BeC	17. Father's Name (First, Middle,	Last)			18. Mother	r's Name (First, Middle,		
ylaı	should be find Mental him marked of	To	Elton Kunselma					el Elizabet		
Maryland	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relations Jeff Oresik /					ror Rural Route Numbe tion Rd., W		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumetic event, the Madical Exertinal must be natified at any injury or other traumetic event, the Madical Exertinal must be natified at ance.		20a. Method of Disposition		20b. Place of Disp	osition (Name of	1	Date	20c. Location - City of	
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	pe isi	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ciecase or injury)	Due to (or a	as a consequence of):					
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	Q		30. Name and address of person				1	MD 01707		
	St	atė	Alan Carroll, 31. Date filed (Month, Day, Year) 32. Ré gi			burg,	KID 21/2/		
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			For State	State of Ma	aryland		artment of H <i>rtificate of L</i>			giene Reg. No.	2006	4	33
			Registrar 1. Decedent's Name (First, Middle, La	ist)			timodio or z		2. Date of Dea	ath		3. Time of	Death
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	/Medic Examin	aı i	4a. Facility Name (If not institution, given				4b. City, Town, or	Location of Death		4c.	County of Dea	th	
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	Funeral		,	Sex 7. Age 1.XXIM 2.□F	e (In yrs. Ia 90	ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da	y, Year)		thplace (State of	
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	how		10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside Ci	•
	e Ma	Director	Maryland Frederic	k	Fred	erick						1 🗆 Yes	
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Marked other then "naturel", or items 23a or 28a-f show astic event, the Medical Examinar must be notified at		10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Co	ountry?	
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2	r iten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅			If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Black, Whi	te, etc.	
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7	Hygie Hygie ther i	e Co	17. Father's Name (First, Middle, Las	t)		Super.	intendant	18. Mother's Nam			truction Sumame)	on	
2	id be entat ked o	00	John Newton Phill	ins				Maggie M.	Rich				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hygiene 27 is marked other then "naturel", or flems 23a or 28a-f show eny injury or other traumatic event, tra Medical Examinar must be notified at once.	۲	19a. Informant's Name/Relationship	er, City o	r Town, State,	Zip Code)							
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			shock or leart failure. List only	one cause on each li	ne.		· · · · · · · · · · · · · · · · · · ·	3, 1	,			Onset and	Death
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ö	Phys r this gral di	2:	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ıry	28b. Time o	III JUA	4 Ku Inuising H	28d. Describe			ecity)	
0	Attending or death. ector: After by the fune	Certification:	1 Natural 5 Pending 2 Accident investigati	(Month, Da	iy Year)	Injury		k? Yes 2 ∐No					
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	icai	(Check only 2 Medical Ex	hysician: To the best	of examinat	wledge, dea tion and/or in	th occurred at the tirnvestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner a d place, and du	s stated. e to the cause(:	s)
	To the Hos within 24 h To the Fur completely	Medical	29b. Signature and title of certifier	and manner st	ated.		29c. Licens	e number		29d. Da	te signed (Mor	th, Day, Year)	
)	N I S		DE SIGNATOR BITS AND STATEMENT					_	_				
	•		30. Name and address of person wh	o completed cause of	death (Item	1 23a) (Tvoe	D3191	۷]1	vecen	mber 18	, ∠006	
	4		Dr. Julio Menoca					ederick.	MD 217	02			
	Sta		31. Date filed (Month, Day, Year)	- mod-						_			
3	Regist	rar	DEC 2 6 2	006	. D	ture							
DI.	A 41 1 4 7 17	0001		All		7							

06-08903 Alberto Pondexter Please Type or Print in Black Indelible Ink

erto Pondex	ter	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No. 200	5 41131
Physic		7 1. Decedent's Name (First, Middle,Last) Albort Alongo Pondexter Sr Month Day Year	3. Time of Death 2110 hrs
edical Exam	iner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	27101110
		Southbound I 270 south of route 109 Hyattstown Montgomery	
Funera Director		5. Social Security Number 236 62 7075 6. Sex 1 X M 2 F 68 Yrs. 68 Yrs. 68 Yrs. 68 Yrs. 68 Date of 8irth (MM/DD/YYYYY) 9. 8irth Foreign Court	
ии		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
and show s	5	VA Fairfax Falls Church	1 Yes 2 X No
Maryl: r 28a-f ed at o	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Count 3155 Holloway Road 22042 USA	try?
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death v or item	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 1 Yes 2 No specify: White, etc. White, etc.	ck
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003(within giene. her tha	allo	Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
215- 215- be filed stal Hyg ked oth	Be C	Ruffner Pondexter	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importanti: If item 27 is marked other than "natural", or items 23a or 28a-f show any important of the managine when the Medical Examiner must be notified at once.	<u>P</u>		
e, M l and 2 Health item 2'		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or	Town, State
MOF Pages nent of ant: If		Metropolitan Crematory 12/7/06 Alexandri	a VA
Balti bermit Departin mports		21 Signature of Funeral Service Licensee Advent Funeral & Cremation Services Falls Church and Annapolis	
Physicia		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medica Examine	al	failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries	Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
	i.	Sequentially its controllers, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): cause. Enter Underlying Cause C.	
recuted 1 and	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
e execu	ounal - ita	UNPENDED AMENDED IF FEMALE: 23d. Date of delivery Amonth A	
ox 68760, sath certificate be ex attending physician	Me ou	IF FEMALE: 23d. Date of delivery 23d. Date of deli) Day Year
Box 687 death certific	ror use as me	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
D. Bc	g 6	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to	the cause of death?
P.O.		1 Yes 2 No 3 Prot	
cords, law requir	should		topsy findings available completion of cause of
tal Rec cian: The la	, page	1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 26. Place of Death (Check only one)	es 2 No
Vital hysician this certi	ē €	25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other	: Scene
ing Ph	era	. 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	on
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	n by the	The state of the s	ral Route Number, City
Div spital o	filled in by	4 Homicide determined (Specify) Interstate/Express Southbound I 270 south of route 10	
the Ho hin 241 the Fu	completely	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the	ted le cause(s)
To wit	COL		
		Mayure me Shell O.C.M.E. November 23, 21	JU6
5		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	Sta	31. Date filed (Month, Day Year) 7 2006 32. Registrar's Signature	

ORIGINAL

			1 - For State Registrar	State of Maryla	_	artment of H rtificate of L			ene 006	41135			
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death	Day _ Yea	3. Time of Death			
10	Physici /Medi		JUDY LYI		₹			1	3, 200 ⁶				
	Examir	ier	4a. Facility Name (If not institution, give s Holy Cross	Hospital			er Spri	ng		TGOMERY			
	Funeral Director		212 04 0103		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Jan. 31,	1956 ^{9. E}	lirthplace (State or Foreign Country) Maryland			
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits			
	Mary B-f eh	tor	MD Prince	e Geo.		Bladensl	ourg			1. Yes 2 □ No			
	or 28	Sirec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What				
	ath w	rail	4400 Blue Hero				20710		U.S				
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "naturel", or items 23s or 28s-f show any loury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral Director	11. Marital Status 1. ⚠ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Sin, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, W				
2-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)		dent's Usual Occupa		kina 16	b. Kind of Busines	ss/Industry			
2	vithin ne. hen	mpf	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,)	9					
20	Hygie Hygie ther t int, in		17. Father's Name (First, Middle, Last)		Ca	shier	18 Mother's Nam	ne (First, Middle, Ma	N.I	.н.			
Maryland 21215-0036	ould be Mental Marked o	To Be	Forrest Palmo				Vi	rginia T	ia Thompson				
Mai	d 2 st th and 17 le n traun		19a. Informant's Name/Relationship (Type Renita Palmer					ral Route Number, C attsvill					
	r 1 an f Heal ftem 2 other		20a. Method of Disposition		b. Place of Dispo	osition (Name of			c. Location - City				
Ë	Page:		1X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	matory`or other place Church (8/06 E	ickers	on, MD			
Baltimore,	permit. Departrimports any Inju		2) Signatural Service Logo e		10 12	2. Name and Addres	s of Facility S	NOWDEN F		HOME, P.A. e,MD 20850			
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	uted d ansit	Examiner	Sequentially list conditions, france, cause. Enter Underlying Cause (Disease or injury that initiated events			Pancrea	tic Can	cer					
8760,	icate be executed physician and s the burial-transit	ai Exa	resulting in death) Last	Due to (or as a cons	sequence of):								
687	ficate p phys	edicai	0										
.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ∑No 9 □ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	lelivery Day Year			
Ω.	that the de led by the a	Ph	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute	to the cause of death?			
ords,	w requires been sign should be	ted by						1 ☐ Yes	2 No 3	Probably 4X Unknown			
Records,	The law ate has be	Completed						24a. Was an autopsy performe 1 ☐ Yes 2 ☑	prior t	autopsy findings available of completion of cause of ?			
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ion	Attending Physician: r death. sctor: After this certific by the funeral director.	ation:	27. Manner of Death 1 ☆Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Work	at ? ′es 2 □ No	28d. Describe how	injury occurred				
Division of Vital	P # P P	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,			
	To the Hospital or within 24 hours after To the Funerel Direction completely filled in the funerel or the funerel filled in the fune	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	nician: To the best of my liner: On the basis of exame and manner stated.	knowledge, deat ination and/or in	h occurred at the tim vestigation, in my op	e, date and place inion, death occu	, and due to the caus rred at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)			
	V Vithiu	×	29b. Signature and fitter of certifier	3/ong) 11	ND	29c. License D6	number 3390	29d	Date signed (Mo	oth, Day, Year)			
	, 0		30. Name and address of person who co Etonde Tarkang	pleted cause of death (In The Musonge,	ltem 23a) (Type, M . D .]	Print) 500 For	est Gle	n Rd, Si	llver 5	20910 pring,MD			
	Sta		31. Date filed (Month Day Year)	32. Registrar's Si	gnature	banks							

06-09371 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For State Amend #5 State of Maryland Department of Health and Mental Hygiene

Certificate of Death Nicole D. Pinkett 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day December 8, 2006 **Medical Examiner** 1753 hrs NICOLE DOMINIQUE PINKETT 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross HOspital Silver Spring Montgomery Social Security Number 578 If Under 1 Year 6. Sex 7. Age (In yrs, last birthday) If Under 24Hrs. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Wash DC Months Days Hours Min Director 02/28/73 1 M 33 2 x F 579-02-3664 Usual Residence of Decedent È 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits or items 23a or 28a-f show must be notified at once. 1 XXYes 2 No Silver Spring permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Montgomery Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 USA 13825 Castle Blvd. Apt. #21 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Yes 2 X No Black f Yes, Give Year 3 Widowed Divorced 1 Yes 2 No specify: Specify ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Freddic Mac Copy Specialist 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charles C. Pinkett Lorie N. Monroe Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $13825\ Castle\ Blvd.\ Apt.\ 21,\ Silver\ Spring,\ MD$ ဥ Lori Pinkett / Mother 20904 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 12-16-06 Beltsville, MD Donation 5 Other Specify Chesapeake Crematory 21. Signalure of Funeral Service License 22. Name and Address of Facility Strickland Funeral Svcs. Allentown Road, Camp Springs, MD 20748 Part I. Enter the disease, or ec mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Hypertensive cardiovascular disease Death Immediate Cause (Final disease €xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical signed by the attending physician are detached for use as the burial -Xunpended AMENDED #23a,27,perME Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy Day Fetal death Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Aug 18, 2006 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ⋧ Yes 2 ✓ No 3 Probably 4 Unknown Completed After this certificate has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be Other₄ examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes ၀ 27. Manner of Death 28a. Date of Injury (Month, Day,Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) within 24 hours at To the Funeral L determined 4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 9, 2006 30. Name and address of person who complete ause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar' Signati

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTFM#18, 20a-20c, perFH, C863, 1/8/07, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** M AMY E. QUIST NOVEMBER 29. 2006 10:12 P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛱 F Days Hours Min 578-86-9576 60 1/20/1946 GHANA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🛛 No Director MARYLAND PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 9500 CONCORD DRIVE 20772 USA Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No BLACK þ Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygience Important: If Item 27 is marked other that any Injury or other traumatic event, the once. CAREGIVER PRIVATE HOME 18. Mother's Name (First, Middle, Maiden Syrname) 17. Father's Name (First, Middle, Last) THEO QUIST MILCHA P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROSALIND-QUIST-HAYNES/SISTER 1058 SPRING VALLEY COURT; FT. WASHINGTON MD 20744 20c. Location - City or Town, State INCA 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 1 Deurial 2 ☐ Cremation 3 MR Removal from State 4 ☐ Donation 5 ☐ Other (Specify) UKN 1/19/2007 KETA-VUI CEMETERY KETA, CHANA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME Myelin T. Weber 11800 NEW HAMPSHIRE AVENUE; SILVER SPRING MD 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician In trocerebro disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trai Box 68760 attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. by the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐No 24a. Was an page 2 s autopsy performed? certificate Keng U 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this After thi 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director: A 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0037066 11-30-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6/88 Oxon 14/1 Rd# 70 Opaig beagu, m.D Uchechi 0x0n Hill mp 20745

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For AMEND#5 Per FH. State AACO HEALIH DEL Registrar	State of Maryla Pr. 12/19/06 CM		artment of H			ene g. No.	6		38
	Physici	an	1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day	Year	3. Time of I	
, X	/Medic		Olive Newport Rein					December	5, 20	006	7:50	Ам
7	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of D	eath	4c. County of		o.1	
			Future Care Chesar 5. Social Security Number 6. Sex		s. last birthday)	Arnold If Under 1 Year	If Under 24	Hrs. 8. Date of Birth			ace (State or	r Foreian
	Funeral Director			M 2KX 96	Yrs.	Months Days		Ain. (Month, Day,	rear)	Count Engla	ry)	1 Greigh
3	2		Usual Residence of Decedent					,,				
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4	Bor	Funeral Directo	10e. Street and Number			10f. Zip Code 21012			g.Citizen of W Lited St		•	
4	ns 23	era	562 Melissa Court	2. Was Decedent Ever in	U.S. 13.1		lispanic Origin			- America		
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1215-0036	ited with recovery and local with the way and tall typical. Ital typicals. Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retire	ation during most of	working 1	6b. Kind of Bus	iness/Indi	ustry		
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altimore, Maryland 21215-0036			20a. Method of Disposition 1 Burial 2 Cremation 3 Re	emoval from State		natory or other plac			0c. Location - C			
timor	tment tant: tant:		4 □ Donation 5 □ Other (Specify)	ва.		Cremator			ltimore		-	
Ba	Department (Important: If eny injury or once.		21. Signature of Funeral Service License	Θ				John M. Tay ucester St.			7 -72	11.
		73 - 53	23a. Part1. Enter the disease, or complic	cations that caused the de							Approximate	
4			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	0		/	A			Interval Betw Onset and D	een eath
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ŏ	attending p	In/M	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregative birth 2 ☐ Fe		Ectopic pregnancy			23d. Date	of deliver	у	
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Record	ate has	Completed				····		24a. Was an autopsy perform	_ pr	or to com	sy findings av	use of
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	w 15	OB	examiner?	ospital:	☐ ER/Outpatien	t 3 DOA Oth	200	ng Home 5 Resider		(Specify)	10 110	
0 8	ter th neral	n: T	27. Mann i Death 1 Patural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur Wor		28d. Describe how				
OS S	Attending ir death. ector: After by the fune	catic	2 ☐ Accident investigation				Yes 2 □ No					
Division of	after d Direct in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (Stre City or Town,		or Rural	Route Numb	er,
	ours a ours a herel [29a, Certifier 1FT Certifying Phys	icien: To the best of my kr	nowledge death	occurred at the tir	me date and n	lace, and due to the cau	se(s) and man	nor as sta	atod.	
2	To title prospile to Attendaring the within 24 hours after death. To the Funered Director: After this completely filled in by the funeral is	edical	(Check only 2 Medical Examination)	ner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	ppinion, death o	occurred at the time, dat	e and place, ar	nd due to t	he cause(s)	
	within To th	Ž	29b. Signature and title of certifier	11-	11	29c. Licens	Ten. mark dar.	_ ^ /	d. Date signed			
	10				/ (_	0	000	larsvill	12-) -	200	6
	Cr		30 Name and address of person who con	mpleted cause of death (Ite	em 23a) (Type,	Print)	. 11.1	1 200 :-11	1 11	7 3	2110	8
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	anstiw	1211	10151111	K / V I	100	170	
	Registr		DEL 0 6 ZUI	No.	15 100	and ()					

Division or Vital Records, P.O. Box 68760,

State

31. Date filed (Month, Day, Year) DEC 0 6 2006

29b. Signature and title of certific



30. Name and address of person who completed cause of death (item 23a) (Type, Print)



29c. License number

D24804

29d. Date signed (Month, Day, Year)

12-2-2006

Registrar

			For State Registrar	State of Mary		artment of <i>rtificate of</i>		and Mental	Hygie Reg.	2000	e-repaired	40
1	Physici	an	1. Decedent's Name (First, Middle, Last					Mon		Day Year	3. Time of	
	/Medic		Fred Dewey Roundy,			1 # 67 F			ember !	5, 2006	6:12	M q
-	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location o	of Death		4c. County of De		
			Washington Adventist 5. Social Security Number 6. Se		yrs, last birthday,	Takoma F	r If Under	24 Hrs. 8. Date	of Birth	Montgome 9.8	irthplace (State o	r Foreign
	Funeral Director			M 2□F	84 Yrs.	Months Days	Hours	Min. (Mon	th, Day, Ye 27, 19:	22 Mar	yland	
* *	P.		Usual Residence of Decedent	140	0.5. T.						10d. Inside Cit	b. Limita
	anyla	_	10a. State 10b. County		c. City, Town or L						1 🗆 Yes	-
	the M	Director	Maryland Montgom 10e. Street and Number	ery	SLIV	er Spring			10g.	Citizen of What 0	Country?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f ahow important: if item 27 is marked other than "natural", or iteme 23a or 28a-f ahow any injury or other traumatic avant, it is Medical Examination to notified a once.		10211 Southmoor Drive				20901			USA		
	death me 2	nera	11, Marital Status	12. Was Decedent Ever	r in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Ori	gin? (Specify Yes	or No-	14. Race - Arr Black, Wh	nerican Indian,	
9	or its	by Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☒ No			10.7	Specify.Whi		
8	ural',		3 Widowed 4 Divorced	Year or Dates:	WWII				401			
7	n 72	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	edent's Usual Occu e kind of work don DO NOT use retir	e durina mos	t of working	160	o. Kind of Busines	s/industry	
12	iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Aircr	aft Repair	Superv	isor	U.	S. Air For	ce	
D	Hyg Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (First, I	Middle, Mai	den Sumame)		
/lar	uld by Menta urked	To E	Fred Dewey Roundy, S	r.			Esthe	r Blanche	Higgins	S		
Maryland 21215-0036	2 sho and is mu		19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mail	ing Address (Stree	et and Numbe	er or Rural Route	Number, Ci	ity or Town, State,	, Zip Code)	
	l and feelth im 27 her tr		Nina Ruth Roundy/ W		10211 20b. Place of Disp	Southmoor	Drive,	Silver Sp	-	MD 20901 : Location - City of	or Town State	
Baltimore,	int of H		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	cemetery, cre	matory or other pl		ecember 9,				
T T	rtmer rtant njury		4 □Donation 5 □Other (Specify 21. Signature 1 Funeral Service Licens	1		oln Cemeter		2006		entwood, M	aryranu	
Ba	Depa impo any i		1 AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	I Colo		rancis J.					0001	
176			23a. Part1. Enter the disease, or comp	lications that caused the		00 Univers					Approximate Interval Bets	
E	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	J 1/1	Trato	v d	Sil	1112			On et and I	
	/Medical		resulting in death)	Due to (or as a co	onsequence of):	. 0	Jan.				1131	U p
g	Examiner		Sequentially list conditions	b. Ren	al	Lail	uv				11/3/	06
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):	0601	110	`^			12/5/	n (
_	cate be executed physicien and the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a co	insequence of):	au			_		10731	٠>
8760,	sicien buria	icai E		,								
687	ificate g phys	edic	-	d								
Box	iaw requires that the death certifica as been signed by the attending ph 2 should be detached for use as it	Physician/Med	23b. was decedent pregnant	23c. If yes, outcome of p		□Ectopic pregnan	104			23d. Date of d		
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time		Other (specify)				Month	Day ^	Year
P.0	at the de by the a stached (hys	9 🗆 Unknown					-	D11111			4
	res tha igned l	ğ	Part II. Other significant conditions co	intributing to death but no	ot resulting in the	underlying cause o	given in Part I	, 236		co use contribute		Unknown
Records,	w require been si should l	Completed	A A A A A	000 1.	Sca			_		1		
3ec	etaw hast je 2 s	mpi	chapha	Dragn				248	 Was an autopsy performed 	prior to	autopsy findings o completion of c ?	available ause of
a	n: The f ficate ha n. page	e Co	25. Was case referred to medical				00.01		Yes 2			
Vital	Physician: 1 this certificat ral director, p	o Be	examiner?	Hospital: 1 X Inpatient	2 ER/Outpatie	ent 3 DOA	\thos:	of Death (Check		e 6 □Other (Sp	nacifu)	
o T			27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time					injury occurred	, cony	
ion	Attending r death. sector: Afte oy the fune	atio	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(North), Day 16	ea <i>r)</i> Injury		Yes 2	No				
Division	r Atte er de recto	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	At home, farm, s	treet, factory, offic	Θ		ation (Stree or Town, S	et and Number or . State)	Rural Route Num	iber,
	itai or irs afte rat Dir lled in	O										
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	edical		rsician: To the best of m iner: On the basis of exi and manner stated	amination and/or i							s)
	o the othe	Med	29b. Signature and title of certifier	and marrier stated			nse number			Date signed (Mo		
			1900 h lh	es i		1	045	61	1	2/71	06	
	124/		30. Name and address of person who of	ompleted cause of death	h (Item 23a) (Type	p, Print)				, , (~ X	26612
			Van May	7400	Car	10 (1)	WL.	, lat	oma	2/7/ LPank	, MD.	70717
4	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	South 1		•				

			For State	State of Marylan					2000		1 1
			Registrar		Cei	rtificate of	Death		g. No. UUD	4	41
	Physici	an	Decedent's Name (First, Middle, L. Zoya		alli			2. Date of Death Month Dec. 6	Day Year	3. Time of 0	
	/Medic		4a. Fecility Name (If not institution, gi			4b City Town o	or Location of Death		4c. County of Deat		, a
	Examin	er	6601 Garrett	_		Rockv			Montgom		
	Funeral		5. Social Security Number 5.52-48-3742 6.	Sex 7. Age (In yrs. 1 ☐ M 2 ☐ 7 7 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 4/28/	Year) 9. Birtl	nplace (State or untry)	Foreign
	Director		Usual Residence of Decedent	- 1	113.			4/28/	1935 KU	ıssia	
	yland		10a. State 10b. County		y, Town or Lo					10d. Inside City	
	Ba-f el	ctor	MD Montg	omery R	ockvi	TIE				1 🗌 Yes	2 € No
	death with the Maryland me 23a or 28a-f ehow	Director	10e. Street and Number	D = = 3		10f. Zip Code 2085	5	10	g. Citizen of What Co USA	untry?	
	eath v	Funeral	6601 Garrett	12. Was Decedent Ever in U	.S. 13. V		dispanic Origin? (S	pecify Yes or No-	14. Race - Ame	rican Indian,	
	be filed within 72 hours after death with the Marylan de Hydjene. I al Hydjene. I other then "naturel", or Heme 23a or 28a-f ehow event, the Mudical Examinar man be notified at		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📉 No		If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	Bleck, White		
2	within 72 hours after ene. then "naturel", or ite he Mudical Exaridies	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:			White	
2	natu	Completed	15. Decedent's (Specify only highest g		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	king	6b. Kind of Business/	ndustry	
7	withir iene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) 4			Broadc	aster	Voice of	Amer	ica
פ	e fited of her vent, I	BeC	17. Father's Name (First, Middle, Las		1			ne (First, Middle, M			
<u>ya</u>		To E	Leo Karpenko		_			tina Am			
=	2 sh and is m		19a. Informant's Name/Relationship Lynda Ralli/I				and Number or Ru		City or Town, State, 2 Wood, Mary		20855
_	1 and Health Iem 27 other to		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		-	t0c. Location - City or		
DE L	Pages nent of int: if it		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Hemovai from State C	ate o	f Heave	n Cem.1	2/08/06	Silver	Spring	g,Md
Baltimore,	permit, Pages Department of I important: if it eny injury or o		21. Signature of Funeral Service (19		ř	HITE INPAD	s Rinald	I FUNER	AL SERVI	CE,P.A	
<u> </u>	83 = 8		haly Oth	Jo C					ver Spri		
н			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the deal ty one cause on each line.	th. Do not ent	ter the mode of dyi	ng, such as cardiad	or respiratory arre	st,	Approximate Interval Betw Onset and D	ween
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Severe Emp		na					
	Examiner			Due to (or as a consec	quence ot):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to for as a consec	uence of						
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	ruanna of):						
8760,	ete be executed hysicien and the burial-transit			Due to (or as a consec	quanto or).						
687	flicete g phys	edical		d							
Box	leath certific attending p	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		Dectopic pregnanc	.v		23d. Date of del		
о. О	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ဩNo 9 ☐ Unknown	4 Pregnant at time of o		Other (specify)			Month	Day Y	'ear
۵.	res that the de signed by the a be detached t	Phy	Part II. Other significant conditions	contributing to death but not re-	sulting in the u	inderlying cause gi	ven in Part I.	23e. Did tob	acco use contribute to	the cause of dr	eath?
ds,	uires l signe Id be	d by		Artery Disea				1 🗷 Ye	s 2 No 3 Pr	obably 4 □U	inknown
Ö	s been si	ojete						24a. Was ar	24b. Were au	lopsy findings a completion of ca	available
Re	Physicien: The lav this certificete has el director, page 2	Completed						autops perform	ned? death?	2 □ No	luse of
/ita	ertifica ector,	Be	25. Was case referred to medical examiner?					ath (Check only one	9)		
5	Physi this c el dire	2	1 ☐ Yes 2 🔯 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpaties 28b. Time o	nt 3LI DOA		fome 5 ☑ Reside	nce 6 Other (Spe	cify)	
0	Attending Physicien: or death. ector: After this certifice by the funerel director, p	tion	1 2Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year)	Injury	Wo	rk?]Yes 2 □No	200. 0000100 110	Williamy Goodings		
Division of Vital Records,	or Attending Phy after death. Director: After thi in by the funereic	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		nome, farm, st	reet, factory, office		28f. Location (Str City or Town	reet and Number or Ru	ıral Route Numi	ber,
	rs after or of Direction	Cert	, , , , , , , , , , , , , , , , , , ,	Building, oto. (Opposi							
	To the Hospital or #within 24 hours after To the Funerel Direction Completely filled in D	edicai		Physician: To the best of my kn eminer: On the basis of examinated and manner stated.)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and marrier stated.		1	se number		9d. Date signed (Mont		
			1/1/105	2001	166)	D003585	9	Dec.7,20	106	
	10		30. Name and address of person wh		m 23a) (Type,	Print)	1 3		1	MA 200	70
			Leszek Kar	rowiec MD. 5		Frederi	ck Aven	ue Gaith	nersburg,	MG 208)/0
	St: Regist	ate rar	31. Date filed (Month, Day, Year)	2006 32. Higistrar's Sign	₩ .	harte					

06-09617 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Rafael Leimer Ruiz-Reyes 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of De Physician/ Month Day December 17, 2006 0340 hrs Medical Examine Rafael Leimer Ruiz Reyes 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 12202 Middle Road Silver Spring 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Days Honduras 7/05/1969 Director none 37 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County s 23a or 28a-f show a notified at once. Durham Yes 2 X No N.C. Durham hours after death with the Maryland Director 10g Citizen of What Country? 10f. Zip Code Honduras 27707 4230 Garrett Road #I-16 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Yes Honduras White 1 X Yes 2 No Specify Divorced If Yes, Give Year Widowed à 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 MD 21215-0036 Electric Co. Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rafael Ruiz Esmeralda Reyes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ို 12111 Foley Street Silver Spring, Md 20902 Noe Ruiz/Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date Baltimore, 2 Cremation crematory or other place) t: If i Removal from State Cemeterio de permit. Pages
Department o
Important: 12/23/06 Guayape, Honduras Othe 21 Si PHILTPORD RENALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line /Medical Death Acute alcohol intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical X UNPENDED physician the burial -*#23a,PII,27,perME, G864, 2/26/07 TT Box 68760, IE EEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify, signed by the atter 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? of Vital Records, P.O. b 1 Yes 2 No 3 Probably 4 V Unknown Cardiomegaly Completed icate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No the Funeral Director: After this certifi-npletely filled in by the funeral director. 26 Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Other₄ Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ဥ 1 🗸 Yes 28c. Injury at Work' 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: Natural Yes 2 X No 5 Pending unk. Fnd 12/17/2006 Fnd 2:00 am Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be or Town, State) 12202 Middle Road Silver Spring, MD Suicide

the Hospital or Attending Physician: hin 24 hours after death.

0

0

Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifie Tame

4

Homicide 29a Certifier 1

> s of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner

determined

(Specify) house

and manner stated

O.C.M.E.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

December 17, 2006

111 Penn Street, Baltimore, MD 21201

			1 - For State RegistrarAmend #7 p							and M	lental Hy	giene Reg. No	2006	o de la constante de la consta	43
I	Physicia	an	Decedent's Name (First, Middle,	Last)	<u> </u>	1-2000	OTHE				2. Date of De Month		, 2006	3. Time of	
ì	/Medic	al	Darlene L. Rol 4a. Facility Name (If not institution,		ber)		4b. City.	Town, or	Location o	of Death	Decemb		2006 County of Dea	1:00	A M
	Examin	er	College View N				Fr	eder	ick				Frede	rick	
	Funeral Director		220-42-7471	. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.	last birthday) 60 Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Bir Stepte Da Dec 8	28/94/9 200		thplace (State of ountry) [aryland	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside Cit	ty Limits
	e Mary ta-f sh	ctor	Maryland Frede	rick		Fre	deric	.k						M∑Yes	2 🗌 No
	with th	Directo	10e. Street and Number				10f. Zip		01701				en of What Co	•	
	ns 23	erai	700 Tollhouse	12. Was Deced	dent Ever in U	.S. 13.	Was Deced		21701 spanic Orig		ecify Yes or No Rican, etc.)		ed Sta 4. Race - Ame	erican Indian,	
36	rs after or item	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☑ Divorced	Armed Ford 1 Tyes 3 If Yes, Give Year or Da	ces? No tes:	1	fYes,speo 1 ☐ Yes		Specify:	, Puerto	Hican, etc.)		Black, Whi Specify: Wh		
	r2 hou	ted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usua	al Occupa	ition	t of works	ina	16b. Kin	d of Business	/industry	
2121	filed within 72 hours after death with the Maryland Hygiene. ther than 'natural', or Items 23s or 28s-f show int, the M. Jical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of wo. DO NOT us eanin)	OF WORK	ng .		Retai	.1	
Maryland 21215-0036	~ - 0 =	To Be C	17. Father's Name (First, Middle, La								e (First, Middle) Le Blan		Sumame)		
Mary	d 2 shoi th and M 7 is ma trauma		19a. Informant's Name/Relationshi				•	•			Route Numb Freder				7
Baltimore,	permit. Pages 1 and 2 should be Depurtment of Health and Menta Importent: If Itam 27 is marked any injury or other traumatic ev	8	20a. Method of Disposition 1 XBurial 2 ☐ Cremation	☐Removal from S	iaie	Place of Dispo cemetery, crei	sition (Nam natory or o	ne of ther place	9)		Date	20c. Loc	ation - City or	Town, State	1
Ħ	nit. Pa		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		Mt.	0live	t Cerr		-		l/2006 tauffer			Marylan me	ıd
ä	Ped di ma		Youther &	tauther	1		1621	0pos	sumto					ID 21702	
	Physician /Medical Examiner		3a. Part1. Enter(the disease, or conditions) Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	a. Due to (c	or as a consection of the section of	DUE H	er the mod					rrest,		Approximate Interval Betwoen Conset and E	ween Death MOS
760,	ate be executed thysicien and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consec										
00	icate b physic s the b	dicai	Δ.	d											
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown		nth 2 ☐ Feta ant at time of o	al déath 3	⊒Ectopic pr ∃ Other (sp					2	3d. Date of de Month		/ear
	uires that l signed by id be deta		Part II. Other significant condition	s contributing to de	ath but not res	sulting in the u	nderlying c	ause give	on in Part I.		23e. Did t	4		o the cause of d	
Records,	he law req e has beer age 2 shou	Completed										psy ormed?	prior to death?	utopsy findings a completion of cases	available ause of
a	ian: T	BeC	25. Was case referred to medical						26. Place	of Deatl	1 ☐ Yes n (Check only o	2. No one)	1 🗌 Yes	2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
<u>></u>	hysic this ce al dire	ို	examiner? 1 Yes 2 No			ER/Outpatier			4 Nu		me 5 Resi			ecify)	
ion	ath. r: After e funer	ation	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date o (Monti	n, <i>Day</i> Yea <i>r)</i>	28b. Time o Injury	M	28c. Injury Work 1 🔲 \	at :? /es 2 □		28d. Describe	now injury	occurred		
Division of Vital		Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Place	of Injury - At h ig, etc. (Speci	iome, farm, sti	reet, factor	y, office				Street and wn, State)		lural Route Num	ber,
	To the Hospital or within 24 hours after To the Funerel Dircompletely filled in	Medical (29a. Certifier Check only one) Certifying 2 Medical E	Physician: To the caminer: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	ie, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s) a date and	and manner a place, and du	s stated. e to the cause(s)
}	within To the comp	Ž	29b. Signature and title of certifier	lain	MΔ		290	C. License	number 66	75	_	29d. Date	signed (Mon	th, Day, Year)	Ś
	/		30. Name and address of person w	\	of death (Ite	?		le-	MY	1	21716				
^	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 1	2006 32	gistrar's Sign) DUN	selfe.	,		,	/ 10				

		-	State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. 0 6 4 1 4 5
	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 5.45 7
	/Medic Examin	al -	ta. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Funeral		Moran Manor Nursing Home Westernport Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1999. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 218-12-5972 6. Sex 1 Months 1 M
	ryland		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	the Ma 28e-f a	Director	MD. Allegarry Westerriport Rayes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	ath with		424 Hammond St. 21562 United States 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No. 14, Race - American Indian,
036	ours after de al', or items Everniner r	by Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 14. Page 3 No Specify: White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show amy injury or other traumatic event, the Medical Examinar must be notified at ODGe.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk 16b. Kind of Business/Industry Hospital
Maryland 2	uld be filed Mental Hygi irked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last) William Stottlemyer 18. Mother's Name (First, Middle, Maiden Sumame) Florence Baker
Mary	d 2 sho th and M 7 Is ma trauma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Daigle/ son Rt. 2, Box 354, Fort Ashby, WV. 26719
altimore,	Pages 1 an ient of Heal int: If item 2 iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Date 1 Date 1 Date 1 Date 1 Cumberland Crematory or other place) 1 Cumberland Crematory 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Cumberland Crematory 20c. Location - City or Town, State Cumberland Maryland
Balti	permit. Departm importe any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Maryland 21562
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
. 68760,	the death certificate be executed by the attending physician and ached for use as the burial-transit		Due to (or as a consequence of): d
.O. Box	that the death certific ed by the attending p detached for use as I	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1
Q .	The law requires that the tas been signed by bage 2 should be detact	b	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Stoknown
of Vital Records,		Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Ves 2 No 1 Ves 2 No
Vita	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner? 1 Yes Yes No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Yes Territory 1 Yes Yes 1 Yes
	ling After fune	lon: T	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No
Division	Attender deat dector:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Hospite 4 hours Funerel ely fille	edical C	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)
	To the I within 2 To the I complet	Ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)
,			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	VA	2	Dr. Jesus Tan, 4 Broadway, Frostburg, Maryland 21532 31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 1 1 2006 32. Registrar's Signature

DHMH 17 Rev 1/2001

	-	For State Registrar	State	of Marylan				ealth and N D <i>eath</i>	Mental Hyg	iene og. No. 2	006	41146
Physicia	an	1. Decedent's Name (First, Middle, Last)		CENTED D		-			2. Date of Dea Month	Day	Year	3. Time of Death 3:40 PM
/Medic Examin	al	LEONA 4a. Fecility Name (If not institution, give s		STUNKARD umber)		4b. City	, Town, or	Location of Death	DECEMBER	-	inty of Death	
LAdilliii	Ģ.	LAUREL REGIONAL HO	SPITAL					LAUREL			INCE GEO	
Funeral Director		5. Social Security Number 6. Sex 1 \square	M 2∑ F	7. Age (In yrs. 86	last birthday) Yrs.	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day JANUARY 2	, Year)	Cour	place (State or Foreign htry) CHIGAN
		Usual Residence of Decedent			T-man and a							I0d. Inside City Limits
ahow	'n	10a. State 10b. County MARYLAND PRINCE G	ODCE I S		y, Town or Lo	cation	ΤΔΤ	REL				1 ☐ Yes 2 ∑ No
the N	Director	MARYLAND PRINCE G	TONGE 5	<u>' </u>		10f. Z	ip Code		1	l0g. Citizen	of Whal Cour	ntry?
h with	O IE	13303 SANTA ANITA	ROAD					20708			U.S.A.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heatth and Mental Hygiene. Depertment of Heatth and Mental Hygiene. In Infortant: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, it a Medical Examination until to modified at once.	by Funeral		12. Was De Armed F 1 XYes	2 No		Was Dec If Yes, sp	ecify Cuba	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		Race - Americ Black, White,	
2 hours cal Ex		15. Decedent's Edu	cation	Dates: KOREA	16a. Dece					16b. Kind o	of Business/In	
vithin 72 ne. hen "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(1-4or 5+)	(Give	DO NOT	use retired UCATOI	•	rking		SCHOOL	
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should be ind Mental marked umatic av	To B	GEORGE EDWAR	D SEYFF	RED					CHA MARY MO			
12 sho h and h m		19a. Informant's Name/Relationship (Ty		IMED	1				ural Route Numbe LAUREL, MAI			o Code)
1 and Health tem 27 other tr		LYNELLE A. STUNKARD 20a. Method of Disposition	- DAUGE	20b. F	Place of Dispersion	osition (N	ame of		Date		on - City or T	own, State
Pages nent of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from	n State PAR	KLAWN MI ORAH GAI	EMORIA	L PARI	CAND	9/2006	ROCKV	ILLE, MA	ARYLAND
permit. Pages Depertment of Important: If it any injury or once.		21. Signature of Funeral Service Licens	en ce	tie	2	2. Name	PINATI	ss of Facility OI FUNERAL AMPSHIRE AV	HOME, INC.	ER SPR	ING, MAF	RYLAND 20904
1.1		23a. Part1. Enter the disease, or compleshock, or beart failure. List only or Immediate Cause (Final	cations that ne cause on	t caused the deal	th. Do not en	ter the m	ode of dyir	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)		CORONARY A		LSEASE						
uted d ansit	Examiner	Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events	Due t	o (or as a consec	nuence of):							
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ertifica ling ph e as th	Med	IF FEMALE:	20 11 400 0	utoome of proop	2004					224	Date of deliv	
atter for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 Live	outcome of pregn e birth 2 Feta gnant at time of o known	al death 3	□Ectopic □ Other (pregnancy (specify) _			230	. Date of deliv Month	Day Year
w requires that the de been signed by the should be detached	b	Part II. Other significant conditions co			sulting in the	underlying	cause giv	en in Part I.	1	obacco use		the cause of death?
The lar	Completed								24a. Was autop perfo 1 ☐ Yes	med?	4b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2☐ No
ician: sertific ector,	Be	25. Was case referred to medical examiner?	lospital:				Ott		ath (Check only o			_
Physical dir	1. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	11	☐ Inpatient 2 ☐ te of Injury onth, Day Year)	28b. Time		28c. Inju		Home 5 Resid			ıfy)
r Attending Physier death. rector: After this of the the funeral dir	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(M	onth, Day Year)	Injury	М		rk? Yes 2 □No				
	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Pla bu	ice of Injury - AI h Ilding, etc. (Spec	nome, farm, s	treet, fact	ory, office		28f. Location (S City or Tox	Street and N vn, State)	lumber or Rui	ral Route Number,
A Hospitel (124 hours el Euners i Dietely filled i	edicai ((Check only one)	ner: On the	the best of my kn basis of examin anner stated.	dwladga daa ation and/or i	nvestigati	ad at the ti on, in my o	me, data and plain opinion, death occ	u and due to the urred at the time,	causa(s) on date and pla	d manner as ace, and due	to the cause(s)
To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				- 1	29c. Licens	se number		29d. Date s	igned (Month	Day, Year)
6) why			m 92-1 /T	Print'	D	24035		DEC	EMBER 5	, 2006
		30. Name and address of person who c E.S. MACHADO, M.D.,					SPRIN	G, MARYLANI	D 20904			
Sta	ate	31. Date filed (Month, Day, Year)		egistrar's Sign		parti	,					

			1- For Amend Items 23a at of Maryland / Department of Health and M. Per MF. 6864, 02/01/07dhb	lental Hygie	ne 2006	41147
	Physici		1. Decedent's Name (First, Middle, Last) SMITH	2. Date of Death Month	Day Year Z	3. Time of Death 2:15 Am
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Summitt PARE CATMSVILLE 4b. City, Town, or Location of Death CATOUS VILLE		4c. County of Dea	mor E
	Funeral Director		5. Social Security Number 214-36-4542 Usual Residence of Decedent 6. Sex 12 M 2 F 6. 6 Yrs. 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. 1 Under 25 Hrs. 1 Under 25 Hrs. 1 Under 26 Hrs. 1 Under 26 Hrs. 1 Under 27 Hrs. 1 Under 27 Hrs. 1 Under 27 Hrs. 1 Under 28 Hrs. 1 Under 28 Hrs. 1 Under 28 Hrs. 1 Under 29 Hrs. 1 Under 2	8. Date of Birth (Month, Day, Ye July 19	9. Bir 9, 1940	thplace (State or Foreign outlity) Wash. DC
	Maryland -f show iliad at	tor	10a. State 10b. County 10c. City, Town or Location 10c. City Town or Locati			10d. Inside City Limits 1 ∑Yes 2 ☐ No
	vith the	Direc	10e. Street and Number 10f. Zip Code	10g.	. Citizen of What Co	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show miniportant: If item 27 is marked other than "natural", or Items 23e or 28e-f show miniport or other traumatic event, I'm Predict Erac, it arment to notified and once.	by Funeral Director	2607 Kinderbrook Lane 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 No 2 No	ecify Yes or No- Rican, etc.)	U.S.A. 14. Race - Ame Black, Whi Specify: B.	erican Indian, te, etc.
21215-0	d within 72 ho giene. rr than "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator	ng	b. Kind of Business MD ar ilk Proc	nd VA
	ld be filed ental Hygid ked other ic event, I	To Be C		(First, Middle, Mai		
Maryland	d 2 should the and Men 7 is marke traumatic	-	19a. Informant's Name/Relationship (Type, Print) Deborah Curtis-Smith 19b. Mailing Address (Street and Number or Rural 2607 Kinderbrook La			* *
Baltimore,	Pages 1 an ent of Heal nt: If item 2		2007 10110000011 10	ate 200	Laurel,	Town, State
Balti	permit. Departm Importa any inju		22. Name and Address of Facility SNO	n St,Roc	ckville,	•
	Physician		23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Spinal Stenosis with Compl Immediate Cause (Final disease or condition resulting in death)	r respiratory arrest, ications	,	Approximate Interval Between Onset and Death
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	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	A MEDICAL EX	AMMER	-Zm.
8760,	ate be executed thysician and the burial-transit	cal	resulting in death) Last Due to (or as a consequence of): d.	ONED BY "		2_m-
.O. Box 6	ath certitic attending p tor use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of de Month	livery Day Year
Ω	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Therefore the conditions contributing to death but not resulting in the underlying cause given in Part I. Sacrad decorbitus	23e. Did tobac 1 ☐ Yes	4	o the cause of death?
I Records,	9 1 9	Completed	Sacral decisitus	24a. Was an autopsy performed	d? death?	utopsy findings available completion of cause of
Vital	icien: certitic	Be	25. Was case referred to medical examiner? 1. Was case referred to medical devaminer? 1. Other: Other: Other:	(Check only one)		
Division of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely tilled in by the funeral director.	Certification; To	27. Manner of Death 1 Inpatient 2 EP/Outpatient 3 DOA 4 Orsing Hor 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation M 1 Yes 2 No	me 5 Residence 28d. Describe how i	injury occurred	
Divi	ital or At rs after or el Directied in by	Certifi	4 Homicide determined 286. Place of Injury - At norms, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	itate)	
	the Hospital hin 24 hours a the Funeral I	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a place of the date of my knowledge, death occurred at the time, date and place, a place of the date of my knowledge, death occurred at the time, date and place, a place of my knowledge, death occurred at the time, date and place, a place of my knowledge, death occurred at the time, date and place, a place of my knowledge, death occurred at the time, date and place, a place of my knowledge, death occurred at the time, date and place, a place of my knowledge, death occurred at the time, date and place, a place of my knowledge, death occurred at the time, date and place, a place of my knowledge, death occurred at the time, date and place, a place of my knowledge, death occurred at the time, date and place, a place of my knowledge, death occurred at the time, date and place, a place of my knowledge, death occurred at the time, date and place, a place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, date of my kn	and due to the caus ed at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
	Within To To To To To To To To To To To To To	Σ	29b. Signature and Atle of certifier 29c. License number D3 1 9 2 C	29d.	Date signed (Mont	
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	WThervill	e, ma	
	Sta Registr		31. Date filed (Month, Day, Year) OEC - 7 2006 32. Degistrar's Signature			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 5. 200⁶ **Physician** 12:20 PM Bernice SCHLAFFER /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda 7501 Democracy Blvd., #326 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | July 26, 1935 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 😿 F 71 579-44-9548 Director Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23a or 28a-f show miner must be notified at 1 ☐ Yes 2 TNo Director Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20817 United States 7501 Democracy Blvd., #326 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hyglene. Institutal, or items 23 mir; if item 72 is marked other than "natural", or items 23 my or other traumatic event, the Medicial Examiner must sny or other traumatic event, the Medicial Examiner must by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 🛣 1 ☐ Never Married 2 ☐ Married white 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specific If Yes, Give Year or Dates: 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Broker Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minna Sirca Samuel Pollock 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 Easley Street, Silver Spring, MD 20910 19a. Informant's Name/Relationship (Type. Print) Jay Schlaffer, Son permit. Pages 1 and 2: Department of Health a Important; If item 27 Is 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/07/06 20a. Method of Disposition ٥ 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Clarksburg, MD Garden of Remembrance Cemetery in jury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arroshock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 5 a /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burjal-trar Due to (or as a consequence of): Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 Fetal death 3 ☐ Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1☐ Yes 2 No death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide determined

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician; after death.

Director: / within 24 hours af

To the Funeral D

completely filled in

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28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) ignature and title of certifier mo OmE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECKER, mo, DME 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2006 ▶

State Registrar

06-09446		Please Type or Print in Black Indel		
Juana Avelina S		otato of marylana i Boparini		ygiene
		Registrar	eate of Death	Reg. No. 2005 4
Physicia Medical Exami			alinas	2. Date of Death Month Day December 11, 2006 3. Time of Death 1117 hrs
		Facility Name (if not institution, give street and number) 2702 Higbee Road	4b. City, Town, or Location of Death Hyattsville	4c. County of Death Prince George's
Funeral Director		5. Social Security Number none 6. Sex 7. Age (In yrs. last bir		→
è		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town		10d Inside City Limits
/land -f show any <u>once.</u>	tor	MD Prince George's Ad	lelphi	1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	I Director	10e. Street and Number 2702 Higbee Road	10f. Zip Code 20783	10g. Citizen of What Country? El Salvador
r death w or items must be	Funeral	11 Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerto	
2 hours afte "natural", Examiner	Ď	3 X Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a.	1 X Yes 2 No specify: Decedent's Usual Occupation (Give kind of	work done 16b. Kind of Business/Industry
5-0036 iled within 72 he Hygiene I other than "n:	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret Homemaker	Own Home
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Abel Salinas		e (First, Middle, Maiden Surname) Antonia Monge
ore, MD 21215-Cost and a should be filed to of Health and Mental Hygin fritten 27 is marked on her traumatic event, the	ToE		b. Mailing Address (Street and Number or I	Rural Route Number, City or Town, State, Zip Code) Adelphi, Maryland 20783
		20a. Method of Disposition 20b. Place crema	of Disposition (Name of cemetery, tory or other place)	/ Tate / 06 20c. Location - City or Town, State
Baltimore, permit Pages I at Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: Mary 21. Si ya ure of Funeral Serice Licens	pland Nat.Mem.Par	I FUNERAL SERVICE, P.A.
Physician	-i	23a. Part I. Erver the disease, or complications that caused the death. Do n	19241 Columbia B	lvd.Silver Spring.Md 2091
/Medical Examiner		failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Linanition Due to (or as a consequence of):		Between Onset and Death
Sec. Company	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
ecuted and - transit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
lal al	edical	X AMENDED #23a,27,28a #7perFH12/18/06,BW,	-f, perME, g864, 2/6/07 T MbCb	Γ
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Fueurs after death. To the Fueurs Unrector: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	siciar	1 Van 3 d Na 0 University	2 Fetal death 3 Ectopic pregna 5 Other (Specify)	23d Date of delivery ancy Month Day Year
P.O. Bost that the de	by Phy	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
rds, P requires t been sign				1 Yes 2 No 3 Probably 4 Unknown 24a Was an autopsy prior to completion of cause of
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	Completed			performed? 1 V Yes 2 No 1 Yes 2 No
in of Vital ing Physician: After this certifuneral director.	To Be	Tes Z No		only one) ng Home 5 Residence 6 Other: Scene
ion of tending Pheath	• •	1 Natural 5 Pending Find 12/11/2006 FN	Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred unknown
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D To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a Certifier 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or	eath occurred at the time, date and place, and	d due to the cause(s) and manner as stated.
T. v. v. v. v. v. v. v. v. v. v. v. v. v.	Me	29b. Signature and title of certifie	29c. License number O.C.M.E.	29d Date signed (Month, Day, Year) December 12, 2006
		_	11 Penn Street, Baltimore, MD 21	201
S Regis	tate trar	31. Date filed (Month, Day, Year) 2006 32 Registrar's Signature	Garle	

06-09552 Jesus Serrano

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Crivial yiand / Department of Health and Wientai Francistrate of Death Registrar	Reg. No. 200	6 4115						
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Jesus Serrano Serrano Martinez	2. Date of Death16 Month Day Year December 15, 2006	3. Time of Death 0308 hrs						
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville	4c County of Deat Montgomery	h						
Funeral Director	5. Social Security Number none 6. Sex 1 Age (In yrs. last birthday)	. 8. Date of Birth (MM/DD/YYYY) 9 Bi							
and show any nee.	Usual Residence of Decedent 10a. State		10d Inside City Limits 1 XYes 2 No						
n the Maryland 3a or 28a-f sh otified at one	10e. Street and Number 24 South Frederick Ave.#208 20877	10g. Citizen of What Cou El Salva	•						
imore, MD 21215-0036 Jagos I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Process 1 Ves 2 No If Yes, specify Cuban, Mexican, Puerto E1 Salvan 1 X Yes 2 No If Yes, Specify Cuban, Mexican, Puerto E1 Salvan 1 X Yes 2 No specify:	Rican, etc.) White, etc. Vador Specify:	White						
5-0036 ed within 72 hours tygiene other than "natur the Medical Exam Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Carpenter		·						
21215-0036 Juld be filed within 7 Mental Hygiene marked other than c event, the Medies	17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, Maiden Surname) a Julia Martine							
MD 21. d 2 should the the and Merican aumatic even	19a Informant's Name/Relationship (Type, Print) brother Juan Carlos Serrano/ 19b. Mailing Address (Street and Number or F 24 South Frederic	k Ave. #208 Gait	hersburg,						
Baltimore, MD 21215-C permit Pages I and 2 should be filed w Department of Health and Mental Hygi Important: If iten 27 is marked oth injury or other traumatic event, the 1 To Be Co	20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State 4 Dongtion 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Cemeterio de San Vicente 12. Signal for Funeral Service Vicensee	Date 20c Location City of San Vice 22/06 E1 Salv	ente, ador						
Physician	21. Signature of Funeral Service Vicensee 22. Name and Address of Facility D PHILIP Des FINALD 9241 Columbia B 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	r respiratory arrest, shock, or heart	Approximate Interval						
/Medical sxaminer	failure. List only one cause on each line. Cardiomegaly associated with aortic stend immediate Cause (Final disease or condition resulting in death) a. Coronary atherosclerosis Due to (or as a consequence of):	osis and moderate	Between Onset and Death						
red nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
760, icate be executed physician and the burial - transit	Due to (or as a consequence of): d AMENDED AMENDED AMENDED Due to (or as a consequence of): d AMENDED AMENDED AMENDED Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
760, freate be exect 5 physician and the burial - tr	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of deliver							
). Box 68' the death certiff by the attending ched for use as:	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnat 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ncy Month	Day Year						
s, P.O. B ires that the d signed by the d be detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did tobacco use contribute to							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical E:			utopsy findings available completion of cause of						
/ital sician: iis certifi lirector,	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 ✔ DOA Other,4 Nursin	only one) g Home 5 Residence 6 Othe	r						
on of Viewding Phys ath. or: After this he funeral di	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred	·						
Division o spital or Attending nours after death. neral Director: After filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide (Specify)	28f. Location (Street and Number or Re or Town, State)	ıral Route Number, City						
To the Hospital within 24 hours To the Euneral completely filled	29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated								
Ž	29b Signature and title of certifier O.C.M.E.	29d Date signed (Mo	1						
	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State Registrar	31. Date filed (Month Pay, Year) 2006 32 Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 8:21 a M December 3 Joyce Smith Hazel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Social Security Number 6. Sex Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Virginia 87 Director 578-46-7023 May 6, Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at Millersville 1 XYes 2 No Director Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

The mountaint if them 27 is amarked other than "natural", or items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be or 21108 USA 314 Obrecht Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3₺ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dora Childress Mason E. Herndon ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 Obrecht Rd., Millersville, MD Thomas Smith/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 12/9/2006 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenses 3401 Bladensburg Rd., Brentwood, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FAILULE Physician RENAL YEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Dav 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by JN EU MON, A. 1 Tes 2 No 3 Probably 4 Vunknown INTESTINAL OBSTRUCTION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed' ISCHEMIC HEAATITUS 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 TYes 2 TNo investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D0051437

10

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division or Vital Records.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNAPOLIS AAMC IBITOTE

31. Date filed (Month, Day, Year)

UKEOWO

32. Registrar's Signature DEC 0 7 2006

		•	For State Registrar	State of M	laryland / Depa Ce	artment of F			ene 006	41152
	Physici		Decedent's Name (First, Middle, William M. S					2. Date of Death Month Decemb	er 5,2 2 0 0	3. Time of Death 6 4:21р м
	/Medio Examin		4a. Facility Name (If not institution, g	give street and number		4b. City, Town, o Lanha	r Location of Deat		4c. County of Death	
	Funeral Director		5. Social Security Number 6 231-40-6149		Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/30/	9. Birth <i>Cou</i> 33 Clai	pplace (State or Foreign untry) rksville, Va
	faryland •how	ŏ	Usual Residence of Decedent 10a. State 10b. County Md P.G.		10c. City, Town or Lo	dover				10d. Inside City Limits 1 AYes 2 □ No
	with the h a or 28a-1 Lbe notifi	Direct	10e. Street and Number	λ		10f. Zip Code 20785		10	g. Citizen of What Cou USA	untry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other then "netural", or Items 23s or 28s-f show other treumatic event, its Medical Examinal must be notified at	by Funeral Director	8423 Dunbar 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces	s? X No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: B	
Maryland 21215-0036	a within 72 ho plene. Ir then "neturi Ine Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th	Education grade completed) College (1-40	(Give life.	dent's Usual Occup kind of work done DO NOT use retired ntrak	during most of wor	king	6b. Kind of Business/N	ndustry
land ;	12 should be filed within h and Mental Hygiene. 7 le marked other then "iteumatic event, the Me.	To Be C	17. Father's Name (First, Middle, La Moses SkipWi	•				ne (First, Middle, Melso		
	and 2 shorally and N 27 le ma		19a. Informant's Name/Relationship Virginia Skip						City or Town, State, Zi Md 20785	ip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is eny Injury or other tre-		20a. Method of Disposition 1		20b. Place of Disportant Commentary, cree Lincoli	osition (Name of matory or other place n Cemete		Date 2	Oc. Location - City or T Suitlan	
Balt	Departr Departr Importe eny Inja		21. Signature of Funeral Service Lice	a	2	SHEWUATU 5732 Geo	meral l orgia A	Home & C ve NW Wa	remation shington	Service ,DC 20011
8760,	The law requires that the death certificate be executed WWW at has been signed by the ettending physicien and with the detached for use as the buriat-transit units.	dical Examiner	23a. Part1. Enter the disease, or or shock, or head failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Interval Between Onset and Death				
Box 6	that the death certific ed by the ettending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)	,		23d. Date of delik Month	very Day Year
rds, P.O.	quires that the signed by aid be detacted	by	Part II. Other significant conditions Diabetes M		but not resulting in the u	inderlying cause giv	en in Part I.		acco use contribute to	the cause of death?
of Vital Records,		Completed	Hypertensi	on				24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
Division of Vita	To the Hospital or Attending Physicien: Th within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, page	25. Was case referred to medical examiner? 1 Yes 2 Xio Hospital: 2 ER/Outpatient 3 DOA Other 4 Nursing Nursing 4 Nursing 4 Nursing 5						oce 6 Other (Special Injury occurred		
	To the Hospital or within 24 hours after To the Funerel Direction completely filled in I	ledical Cer	29a. Certifier (Check only one) 12 Certifying 2 Medical Ex	Physician: To the be	st of my knowledge, deat of examination and/or in	h occurred at the tin	ne, date and place pinion, death occu	and due to the cau	use(s) and manner as	stated. to the cause(s)
•	To the within comple	Me	29b. Signature and title of certifier 30. Name and address of person with	Do pleted cause of	i death (Item 23a) (Type.	Print)	58446	1	d. Date signed (Month) 2 / 06 / 200	
¢ .		la.	Nadehzda Kov	valchuk, M	d 8118 Go	od Luck	Road L	anham,Md	20706	
	Sta Registi		DEC - 8	2006	we to the	2001/1				

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06-09477	
Karen Leslie	Sau

aren Leslie Saul	State of Maryland / De	epartment of C <i>ertificate</i> of			200	c 1.115		
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	Jorimodic of	Death	2. Date of Death	g. No.	3. Time of Death		
ledical Examine	Karen Leslie Saul			Month December	Day Year 12, 2006	1305 hrs		
3	Facility Name (if not institution, give street and number) Frederick Memorial Hospital		4b. City, Town, or Location of Dea Frederick	th	4c. County of Dea Frederick	ath		
Funeral	5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year If Under 24H	rs. 8. Date of Birth	(MM/DD/YYYY) 9. E			
Director	214-78-8522 1 M 2XF	47 Yrs	Months Days Hours M	n. Aug. 28		eign Country Californi		
'n	Usual Residence of Decedent 10a. State 10b County 10c. (City, Town or Locat	ion			10d Inside City Limits		
ow any	MD Calvert	Chesapea		1 Yes 2 X				
Maryland 28a-f show d at once.	10e. Street and Number	Cricbapca	10f. Zip Code	10	g Citizen of What Co			
the Maryland a or 28a-f sh tiffed at onco	3499 Brookeside Drive		20732		U.S.A	٨.		
with 1 with 1 he not be not	11. Marital Status 12. Was Decedent Ever		as Decedent of Hispanic Origin? (erican Indian, Black,		
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s after rral", niner	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	twork done	Specify: W	hite				
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215-0036 be filed within 7 mal Hygiene riked other than ent, the Medica	17. Father S Harrie (First, Hiladie, Edist)			ne (First, Middle, M				
ID 21215-00; should be filed with and Mental Hygiene 7 is marked other thattie event, the Meric event, the M	Kenneth Howard Cole 19a. Informant's Name/Relationship (Type, Print)	19h Mailin	Sandy g Address (Street and Number o		Cole			
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Dale Thomas Saul, husband		Brookeside Dr.,					
ore, MC es I and 2 s of Health an If item 27 her traums	20a. Method of Disposition 2		sition (Name of cemetery,		20c. Location - City			
imore Pages 1 nent of H tant: If i	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify		an Crematory 12	/14/2006	Alexandri	a, VA		
Baltimore, MI permit Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	zi S nature of Funeral Service Licensee	22.1	Name and Address of Facility Ra	usch Fune	eral Home	P.A.		
	23a. Part I Enter the disease, or complications that caused the di	- 83	25 Mt. Harmony	Tane. Owi	inas. MD	20736 Approximate Interval		
Physician /Medical	failure. List only one cause on each line.			or respiratory arre	st, shock, or near	Between Onset and Death		
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Mor hine and more pure to (or as a consequent or condition)		ntoxication					
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- 8	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequent	ice of):						
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60, te be evecution and sysician and burial - trail	20. 16		ME, C863, 1/5/07 T		23d. Date of deliv	erv		
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OX 6 ath ce attend attend or use	1 Yes 2 No 9 ✓ Unknown 9 Unknown	of death 5 0	ther (Specify)					
~ = & = L	Part II. Other significant conditions contributing to death but it	not resulting in the	underlying cause given in Part I.	23e. Did tot	pacco use contribute	to the cause of death?		
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Division of Vital Records, ral or Attending Physician: The law require rs after death. al Director: After this certificate has been sighed in by the funeral director, page 2 should be artification: To Re Commisted				perform 1 ✓ Yes 2	med? death	?		
tal R clan: T certific	25. Was case referred to medical		26.Place of Death (Chec	k only one)				
F Vit	TV Tes 2 No	2 ER/Outpatien				her:		
ding Ph	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of	Injury 28c. Injury at Work?		ow injury occurred			
Sion Attend or death ector: by the	2 Accident Investigation Fnd 12/12/20		10 pml A		ook drugs_ treet and Number or	Rural Route Number, City		
Division o Spital or Attending tours after death. neral Director: Aft filled in by the func	3 X Suicide 6 Could not be determined (Specify) found			or Town, St. Thurmonr	MD Motel 8			
8 - = 5	29a Centrier	wledge, death occu	irred at the time, date and place, a	nd due to the cause	e(s) and manner as s			
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination	ion and/or investiga		at the time, date a				
2	29b. Signature and trile of certifier		29c License number O.C.M.E.		29d. Date signed (#December 13,			
	30. Name and address of person who completed cause of death	(Item 23a)	J. O.IVI.L.		2000111001 10,			
	Mary G. Ripple MD. Deputy Chief Medical E		1 Penn Street, Baltimore,	MD 21201				
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State of Maryland / Department of Health and Mental Hygiene, For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year December 16.20 Joyce Lynn Sherrill 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL OF CECIL COUNTY ELKTON (ECIL UNION If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1□M 2♥F Director 217-64-4887 May 14, 1954 Marvland Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 ia marked other than "natural", or Itama 23a or 28a-1 ahow other traumatic avant, the Medical Examinar must be inclifted at 1√ Yes 2 No Director Maryland Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 North Main Street 21901 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, elc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: Specify 3 Widowed 4 Divorced B1ack Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Menial Hyglene. Important: If itam 27 is marked other than "ns any injury or other traumatic avant, Ina Media 2006. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Colonel Anthony Webster Delphine Bertha Williams 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald V. Sherrill/Husband 303 North Main Street, North East, Maryland 21901 20b. Place of Disposition (Name of cemetery, crematory or other place)
Delaware Veterans
Memorial Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) December Delaware Memorial 22. 2006 Bear, Delaware 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULSELESS ELECTRIC Physician ACTIVITY /Medical Due to (or as a consequence of): Examiner GASTROINTESTINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iniliated events resulting in death) Last Due to (or as a consequence of): Examiner ANCREA deteched for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at lime of death 5 Other (specify) the 9 Unknown signed by t d be detech Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1. Inpatient 9 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Mapner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Peter death. Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital o. within 24 hours eft To the Funeral Di 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of cer-29c. License number 0063486 2006 December 30. Name and address of o completed cause of death (Item 23a) (Type, Print) HAMADEH ELKTON, MID STREET 106 BOW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2008 Registrar

DHMH 17 Rev 1/2001

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	Examin		4a. Facility Name (If not institution	_	ber)		4b. City, Town, or	Location o	of Death			ty of Death		
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	Funeral		5. Social Security Number	6. Sex 7	Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	Hours 2	Min.	8. Date of Birth (Month, Day	, Year)	Coun	lace (State or try)	Foreign
ļ,	Director		212-20-0528 Usual Residence of Decedent	Λ	84	113.				AUG 20,	1922	De1a	ware	
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside Cit	y Limits
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	r 28a	Director	10e. Street and Number	-		LICCOII	10f. Zip Code			-	l 0g. Citizen of	What Coun	try?	
	h witi		431 Appleton	Road			21921				Unite	ed Sta	ites	
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Maryland 21215-0036	d be ental	To Be	Julian Richar	d Sprv. Sr				Ger	trude	e Edmon	son			
2	Should Mark	-	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street a					n, State, Zip	Code)	
Š	nd 2 lith a 27 is r tras		William F. Sp	rv/Son		105 1	Wedgemont	Driv	e. E.	lkton.	Marv1a	nd 219	21-	
ē,	s 1 a f Hea item othe		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of	ī		ate	20c. Location			
Ë	Page nent c nt: If ry or		1 🖾 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		Gil Mom	pin Ma orial	natory or other place NOT Dorle	2	21, 2		E1kton	. Mar	vland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 ie marked other then "natural", or Items 23a or 28a-f show enty injury or other traumatic event, the Medical Examination must be notified at anote.		21. Signature of Funeral Service	Licensee	~	22 U-	Name and Addres	s of Facility	y Euror	10 D				
m	8 G E 8 8		Daniel	s. Hic	bu	10	Name and Addres CKS Home 3 W. Stoc	kton	Stre	et, Ell	cton, M	laryla	nd 219	21
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	/Medical Examiner		resulting in death)											
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ă	death certifica e attending ph ed for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	nth 2 ☐ Feta ant at time of d		Ectopic pregnancy Other (specify)				M	lonth	Day Y	'ear
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<u>s</u>	Attending ir death. ector: After by the fune	lica	3 Suicide 6 □ Could	not be 28e Place	of Injury - At he	ome, farm, sti	reet, factory, office			8f. Location (S	treet and Num	nber or Rura	l Route Numi	ber.
S	efter Offin Dire	Certification:	4 Homicide	nined 289. Place buildin	ig, etc. (Specif	y)	,,,			City or Tow	n, State)			
	spits hours nera y fille		29a. Certifier 1 Certifyi	ng Physician: To the	best of my kno	wledge, deat	h occurred at the tim	ne, date an	nd place, a	nd due to the o	ause(s) and n	nanner as si	ated.	
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	(Check only 2 Medical one)	Examiner: On the ba and mann	sis of examina er stated.	ition and/or in	vestigation, in my op	oinion, dea	ith occurre	at the time, o	date and place	, and due to	the cause(s	i
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	Π		30. Name and address of person	who completed caus	e of death (Iten	n 23a) (Type,	Print)				,	1/2	1100	
	\		31 Date filed (Month : Day Van	NA FILE	gistrar's Sinna	HD	106 Bou	JA	rect	GIIC	100 I	MD	1721	
	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 19 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CLC MENT YNN BREYEN HD 106 BRW Sneet E18th HD 21321 State Registrar 31. Date filed (Month, Day, Year) 6 2006 32. Registrar's Signature													

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day
DECEMBER 9 **Physician** DONALD 2006 4:47 AM STANLEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 15 M 2 □ F Director 236-34-8428 81 Dec. 9, 1925 West Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Jefferson Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4802 Stockton Court 21755 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status tes 1 and 2 should be filed within 72 hours after. or health and Mental Hyglene.

I flem 27 is marked other than "natural" or its other traumant. Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White 9 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12Highway Inspector State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William E. Stanley Betty Dawson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Stellabotta / Daughter 4802 Stockton Court Jefferson, Maryland 21755 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any Injury or ott December 1 Burial 2 □ Cremation 3 □ Removal from State Moundsville, 4 □ Donation 5 □ Other (Specify) Riverview Cemetery 15, 2006 West Virginia 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service License 1100 N. Maple Avenue Brunswick, Maryland 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Seps15 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner mycloma multiple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are this indicated) Examine burial-transi resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 9 voss hematura wish obstructed 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No tibrillation, 24a. Was an History of mutiple caredal vascular autent parkinson 1□ Yes 25. Was case eferr d to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 npatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P s after death.

Il Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 12/10/2006 omu. CHAN-HING HO, MID. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of the Ave BRUNSWICK MD 21716

32. Redistrar's Signature (FREDERIUS PRIMARY CARE ASSOCIATES) 31. Date filed (Month, Day, Year) DEC 1 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Day Year Charles Edgar Swomley 4:30 PM December 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 X M 2 □ F Months Days Hours **Director** 216-12-5273 88 22, 1918 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits r 28a-f show notified at 1 ☐ Yes 2 XINo Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? aor permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must b 2400-1B Dominion Drive 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 à 1 ☐ Yes 2 🖾 No White Specify: 3 Nidowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Dairy Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Harry Swomley, Sr. Nellie Remsberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Swomley / Son 2400-3B Dominion Drive Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State December 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 12, 2006 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 4 days disease or condition resulting in death) Neumania /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Useass or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical the as attending p 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death 5 ☐ Other (specify) Day 1 ☐ Yes 2 ☐ No ed by the a 9☐Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? (ras)a 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate 25. Was case referred to medical examiner? Division or Vital 1□ Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **№**0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or A 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certi-29c. License number

2

State Registrar 30. Name and add

2006

DHMH 17 Rev 1/2001

(Item 23a) (Type Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:47 AM December 13, 2006 Simmons Virginia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Garrett County Memorial Hospital 0akland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 F West Virginia 1938 Director 236-56-1934 May 12, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or iteme 23a or 28e-f ehow the Medical Examiner must be nutified at 1 ☐ Yes 2√ No **Funeral Director** MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 644 Silver Knob Road 21550 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Completed by Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hyglene. importent: if item 27 is marked other than "na eny injury or other treumatic event, the Mading once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Simmons Luvina Delmar Moats Dove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1617 King Wildeson Road, Oakland, MD 21550 Misty Dawn Schoch, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 12/17/06 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burdock-Durst Funeral Home Katherine 21 N. Second St., Oakland, MD 21550 Succept 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician AKTEM OSCLEROTV CORONARYVIASC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine anding physician and use as the buriel-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical igned by the ettending be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 3 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 20a) (Type, Print) Vev 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 Registrar

DHMH 17 Rev 1/2001

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			State of Maryland /		artment of Health a		ental Hy	- (1	106	41	160
			Registrar 1. Decedent's Name (First, Middle, Last)		tilicate of Death		2. Date of De	Reg. No.		3. Time of	Death
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Maryland 21215-0036	ss 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene, item 23 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be.		T T		ng Address (Street and Number			-			
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			30. Name and address of person who completed cause of death (Item 23a)	/Time				0.0.0.		1	,
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Registrar

DHMH 17 Rev 1/2001

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		lon	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Work?	es 2 🗆 No	28d. Describe ho	ow injury of	curred	
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Di	after Direction by	Certification:	4 Homicide determined	building, etc. (Spe	cify)	and an indicatory, and a		City or Town			
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	4VA	2	30. Name and address of person who comp						•		
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			1 - State Registrar Amend #19b 1. Decedent's Name (First, Middle, Last)	State of Maryl	and / Depa 12–11 ^C 9	artment of H	ealth and Death	2. Date of Deat	eg. No.	6 4 1 1 6 2
	Physici /Medio		Alice C.	S	truck			December 1	Day 2006	
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or		ith	4c. County of D	
			5 Georgetown Roa			Walkers			Frede	
	Funeral Director		5. Social Security Number 220-28-6707 Usual Residence of Decedent	7. Age (In)	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Day,	^{Year)} 29, 1932	Birthplace (State or Foreign Country) Maryland
	yland 10w		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	a-f-e	ctor	Maryland Frederic	.k 1	Walkersv	ille				Yes 2 □ No
	3a or 28	i Director	10e. Street and Number 5 Georgetown Road			10f. Zip Code 21793	}	1	0g. Citizen of What	Country?
336	72 hours after deeth with the Maryland Instural', or ttems 23a or 28a-f ehow digal Examinar must be inclined at	by Funeral	11. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi. If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- irto Rican, etc.)		umencan Indian, White, etc. white
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelih and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show appringury or other traumatic event, Ita Medical Examination must be rediffied at once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired; taker	luring most of w	orking	16b. Kind of Busine	
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Baltimore,	ages 1 an nt of Heel nt if Item 2 or other		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ R	emoval from State	o. Place of Dispo cemetery, cren	sition (Name of matory or other place	e)	Date	20c. Location - City	or Town, State
탪	nit. Pa entme ortant injury		4 □Donation 5 □Other (Specify) 21. Sign ture of Funeral Service License			Memorial Name and Addres	1			Maryland
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8760,	icate be executed physicien and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons						
O. Box 6	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as for	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
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)	To t withi To t	Σ	29b. Signature and title of certifier		, and	29c. License	186	6 0	ecembe	onth, Day, Year) 27 7, 2006
	O		30. Name and address of person who co	mpleted cause of death (tem 23a) (Type,	Print)		,	,	
	1 "		Kanan Hudhud,	mo 46B 7	homas	Johnson J	prine	Frederic	ct. NO	21702
	Sta Registr		31. Date filed (Month, Day, Year) DFC 1 1 201	32. Aegistrar's Si	gnature	seek)				

06-09537 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jarvis Ira Stern State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ Decedent's Name (First, Middle, Last) Month Day December 14, 2006 1507 hrs **Medical Examiner** STERN IRA JARVIS 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Ocean City Worcester 1100 Edgewater Ave, Apt. B If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY 9 Birthplace (State of 7. Age (In yrs last birthday) 5. Social Security Number **Funeral** Foreign Pennsylvani. Days Hours Director 10/26/1976 30 161-58-8039 1<u>X</u> M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County any 1 X Yes 2 No items 23a or 28a-f show ust be notified at once. Crisfield Somerset Maryland hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21817 14 Minden Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. White, etc. Armed Forces? Never Married 2 X No Yes White 4 X Divorce If Yes, Give Year Yes 2X No specify. ₫ 6b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene Important: If item 27 is marked other than "1 injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 Automobile Dealership Servicing 12 1B.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Mary Maszczenski Be Richard Arnold Stern 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Minden Avenue - Crisfield, Maryland 21817 Patricia M. Stern (Mother) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Salisbury, Maryland 12/19/2006 Salisbury Crematory Donation 5 Other Sp prature of Fune al Service icense Beth Bradsahw 22. Name and Address of Eacility Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, MD 21817 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Fentanyl intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (D Physician/Medical ΙF 23 ò Completed

been signed by the attending physician and hould be detached for use as the burial - transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, certificate has been

Be ို

Certification:

Medical

State

Registrar

Margarita Korell MD

DEC 2 2

2006

31. Date filed (Month

(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	f):					
X UNPENDED	AMENDED #23a.PII.	27.28a-f. permo	e. G863, 1/5/07	' TT			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de	2 Fetal death	3 Ectopic pregna	ncy	23d. Date of de Month	elivery Day	Year
Part II. Other significant conditions	contributing to death but not r	esulting in the underlying	cause given in Part I.	23e Did toba	cco use contribu	ite to the caus	e of death?
Cocaine use				1 Yes	2 V No 3	Probably 4	Unknown
				24a. Was an autopsy perform	prid? dea	ere autopsy fin or to completio ath? Yes	idings available on of cause of 2 No
25. Was case referred to medical		2	6.Place of Death (Check	only one)	•		
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DO	OA Other Nursin	g Home 5 Re	esidence 6 🗸	Other: Scene	
27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28	8c. Injury at Work?	28d. Describe how	v injury occurred	1	
1 Natural 5 Pending 2 Accident Investigat	Fnd 12/14/2006		1 Yes 2 No	unknown		D I D A	a Niverbas City
3 Suicide 6 X Could not	t be	ome, farm, street, factory,	office building, etc.	28f. Location (Stroor Town, State	$_{ m ie)}~1100~{ m Ed}$	gewater	Ave. Apt
4 Homicide determine	(Specify) House				City, MD		
	cian: To the best of my knowled er:On the basis of examination a						(s)
20h Signature and title of portifier	and manner stated.	290	License number		9d Date signed	(Month Day	Vear

OCME

111 Penn Street, Baltimore, MD 21201

December 16, 2006

within 2 **To the** 1

Sec.

cause of death (Item 23a)

Registrar's Signature

1000

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 6, 2006 ea Victoria Elizabeth Tippett 07:55 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 3 F 231-20-9538 86 July 21, VA Director 1920 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Gaithersburg 1X Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Odenhal Avenue #811 20877 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. ģ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Caregiver 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ada T. Hall Henry Lowry ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 7904 Badenloch Way Unit 302, Gaithersburg, MD Virginia Gordon (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory-or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Dec 7 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2006 0 22. Name and Address of Facility Devol Funeral Home 21. Signature of Funeral Service Licensee TRACY A. STUVER 10 E. Deer Park Drive, Gaithersburg, MD, 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Days a. Respiratory Failure /Medical Due to (or as a consequence of): Examiner Pneumonia Days Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed Months Congetive Heart Failure the burial-tran and Due to (or as a consequence of): physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 2**K** No 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 1∐ Yes 2X No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ∐ Yes 2**X** No 1 XInpatient 2 ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After or Attending 1 🛛 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, 24 hours after death Funeral Director: filled in by the Hospital within 24 hor To the Fune completely fi

29c. License number

70064560 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive, Rockville, MD 20850 2006

🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Medical

29a. Certifier

(Check only

Physician /Medical

Please	State of Mar					-	•	DIE.	
1 - For State Registrar	Oldie of Mai		ertificate of l		liid ivici		. No. 2 0	06	41165
Decedent's Name (First, Middle, La	ist)				2.	Date of Death			3. Time of Death
RICHA	RD K.	TINSLEY	SR.			Month DEC.	Day 4, 20	Year 106	4:05 P M
4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of	f Death		4c. County	of Death	
5405 QUINTANA				ERDAL			PRINC	E GEO	RGES
5. Social Security Number 6. S	Sex 7. Age (1)X M 2 ☐ F	In yrs. last birthday	Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Y		Count	·
407-32-2144 Usual Residence of Decedent		78 Yrs.		L]_D	EC. 3,	1928	KE	NTUCKY
10a. State 10b. County	1	Oc. City, Town or	Location					10	d. Inside City Limits
MD. PRINCE G	EORGES		RIVERDAI	E					1 X Yes 2 □ No
10e. Street and Number			10f. Zip Code			10g	. Citizen of \	What Coun	try?
5405 QUINTAN				737				S.A.	
11. Marital Status	12. Was Decedent Eve Armed Forces?		 Was Decedent of H If Yes, specify Cuba 	ispanic Orig n, Mexican,	in? (Specif , Puerto Ric	y Yes or No- an, etc.)		e - America ck, White, e	
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 MYes 2 □ No. If Yes, Give Year or Dates:	1947-	1 ☐ Yes 2 📉 No	Specify:			Specify	/: TITLE T	тr
15. Decedent's E	ducation	1950 16a. Dec	edent's Usual Occup	ation		16	b. Kind of B	WHI bnl/ssenisu	
(Specify only highest gri	ade completed) College (1-4or 5+)	(Giv	re kind of work done of DO NOT use retired	during most)	of working				•
12	College (1-401 34)		BUS DRIVE	R				METRO	
17. Father's Name (First, Middle, Last	")			18. Mother	r's Name (F	irst, Middle, Ma	iden Suman	ne)	
WILLIAM F	RANKLIN TI	NSLEY			GRACI	E ALI	CE C	OX	
19a. Informant's Name/Relationship			iling Address (Street						Code)
BRENDA J. TINS	LEY/DAUGHTE	20b. Place of Dis	QUINTANA	ST.,	RIVE	-			un Chata
20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □		cemetery, cr	ematory or other plac				c. Location -		
4 □ Donation 5 □ Other (Special Service Lice			RS CREMATO 22. Name and Addres		2-19-2	2006	RIVERD	ALE,	MD.
A.A. Cha	mhusa	(CHAMBERS F 801 CLEVE	UNERA	L HOM!	E & CREI	MATORI ALE, M	UM, P D. 20	.A.
23a. Part1. Enter the disease, or comshock, or heart failure. List only	nplications that caused the one cause on each line.								Approximate Interval Between
Immediate Cause (Final disease or condition	CANCER OF	LUNG							Onset and Death
resulting in death)	Due to (or as a	consequence of):							
Sequentially list conditions,	b								
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a o	consequence of):							
that indiated events resulting in death) Last	cDue to (or as a c	consequence of):							
l l									
	d								
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Da	te of delive	ту
in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2		☐Ectopic pregnancy ☐ Other (specify)				Mo	nth	Day Year
9 □Unknown	9□ Unknown						<u> </u>		
Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause give	en in Part I.		23e. Did toba	cco use cont	nbute to the	e cause of death?
COPD, CVA						1 🔀 Yes	2 🗆 No	3 Proba	ably 4 ☐Unknown
HYPERLIPIDEMI.	A					24a. Was an autopsy	24b.	Were autop	sy findings available
BLADDER CANCE	R					performe 1 ☐ Yes 2 ☐	d? i	death?	2 🗆 No
25. Was case referred to medical examiner?	Manitali		104		of Death (C	Check only one)			
1 Yes 2 No	Hospital: 1 Inpatient 28a. Date of Injury	2 ☐ ER/Outpati		4 🗆 1401	rsing Home	- A)
27. Manner of Death 1 ☑Natural 5 ☐ Pending	(Month, Day Y	(ear) Zeb. Time Injury	Worl	γατ c? Yes 2∐N		Describe how	injury occur	rea	
2 Accident investigation 3 Suicide 6 Could not t	De Place of Injury	- At home farm	street, factory, office	163 2		Location (Stree	et and Numb	er or Rural	Route Number,
4 ☐ Homicide determined	building, etc.		stroot, tastory, ombe			City or Town,			
29a. Certifier 1 Certifying P	hysician: To the best of a	kamination and/or	ath occurred at the timinvestigation, in my o	ne, date and pinion, deat	d place, and th occurred	I due to the cau at the time, date	se(s) and ma	anner as sta	ated. the cause(s)
29b. Signature and title of certifier	and manner state	<u>. </u>	29c. Licenso	e number		290	. Date signe	d (Month, E	Day, Year)
DX Plyer			D0	05095	1		DEC.		
30. Name and address of person who									
			JORTH AVE.	, SUI	TE 240	00, RIV	ERDALE	, MD.	20737
31. Date filed (Month, Day, Year) DEC - 8	32. Registrar's		berte						
	LUUU KA	, Ji p	god "Sillor"		-				

State Registrar

			1 - For State Registrar	State	of Maryla		artmen rtificat			and M	lental Hyg	giene	/ U U b		166
П	Dhysisi	20	Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	ath Day	/ Yea		of Death
	Physici /Medio		Mildred	L.	Т	hompsor	1				Decembe			11:	46 P
	Examir		4a. Facility Name (If not institution	n, give street and no	um <i>ber)</i>		4b. City,	Town, or	Location o	of Death		4c.	County of De	ath	10 1
			3200 Castlelei				Be1t					Pr	ince G	eorge	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F		. last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	y, Year)	9. B	irthplace (State Country)	or Foreign
	Director		578-09-8086		102	Yrs.					09/29/	1904		NC	
	and w		Usuat Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. tnside	City Limits
	f ahd	ō	D G												s 2 No
	158 P	Director	D.C.		Wa	ashingt	On 10f. Zip	Codo				10- 04	zen of What (
	with	ā												ountry?	
	eath	Funeral	5223 Western A		edent Ever in U	10 10		20015		-in2 /Co	noifu Van as Na		S.A.	nerican Indian,	
	item item	Š	1 ☐ Never Married 2 ☐ Mar	Armed F	orces?	J.S. 13.	f Yes, spec	offy Cuba	n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		Black, Wh		
99	irs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes G	ive		1 🗌 Yes	2 % No	Specify:				Specify:	White	
ŏ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or itema 23a or 28a-f ahow aumatic event, the Medical Examinational be notified at	ed	15. Deceden	t's Education		16a. Dece	dent's Usua	al Occupa	ation			16b. Ki	nd of Busines		<u></u> -
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7	T the	E	12	College	(1-4or 5+)	Bea	utici	an				Bea	uticia	n	
힏	Hyg ethe	BeC	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	First, Middle,				
a	id be lental ked o	To B	Charles Lamk	in					Lorai	ine	Harper				
<u>~</u>	should nd Men marke umaric	_	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address				al Route Numbe	r, City o	r Town, State,	Zip Code)	
Baltimore, Maryland 21215-0036	ages 1 and 2 should b nt of Health and Ment t: if item 27 is marked f or other traumatic e		Michael L. Tho	muson / S	Son						eltsvil]				15
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e E	Pages nent of int: if it		1 ∑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Julian					2/20	/2006	ئا 7 ما ۸	natan	77 A	
₫	permit. Page Department i Important: if any injury or once.	1	21. Signature of Funerat Service		THE PARTY	LING COL	. Name an	d Addres	s of Facility	2/20 v .Tos	eph Gaw	Arii	ngton,	VA	
Ba	Den imp		h/t/	0 R	1.774	5	L30 W:	isco	nsin	Ave.	NW Was	hine	s sons	Inc.	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	a sed the dea								scon, L	Approxim	
			shock, or heart failure. List trnmediate Cause (Finat	only one cause of	each line.			· - , · · ·						Interval B Onset and	etween
a	Physician /Medical		disease or condition resulting in death)		conary I		iseas	e					*	Years	
	Examiner			Due to	(or as a conse	quence of);									
		6	Sequentially list conditions,	b. Owa to	(or as a consec	suanca offi								_	
	ted nsit	F	Sequentially list conditions, if any, bading to finite diatactuses. Enter Underlying Cause (Disease or injury		(, , , , , , , , , , , , , , , , , , , ,									
	aj-tra	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):									
8/60	cate be executed bhysician and the burial-transit	dlcal E													
289	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit) F		d											
×	eath certific attending pl	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregn	ancy							Od Data of d	li	
ROX	atter	clar	in the past 12 months?	1 Live	birth 2 ☐ Feta nant at time of d	aldeath 3□	Ectopic pro					4	3d. Date of de Month	Day	Year
o.	the d ched	ysi	1 □ Yes 2 ☒ No 9 □ Unknown	9□ Unkr			201101 (3)	ocny)							
J.	that the dended by the a		Part II. Other significant condition	ens contributing to d	leath but not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco u	se contribute	to the cause of	death?
Vital Records,	uires sign d be	d by									1 🗆 Y	es 25	StNo 3∏F	robably 4	Unknown
Ö	w require been si should b	Completed													
ĕ	The lav	E D									24a. Was a autops perfori	sy	prior to	utopsy finding comptetion of	s available cause of
<u></u>	r: Th icate										1 Yes		death? 1 ☐ Ye	s 2□No	
<u> </u>	Physician: Tribis certificate	Be	25. Was case referred to medical examiner?	Hospital:				1 014		of Death	Check only or	-			
<u></u>	Phys this at dii	5	1 ☐ Yes 2 € No 27. Manner of Death	10		ER/Outpatien			4 🗆 1401				Other (Sp.	ecify)	
ב	ding l	5	1 X Natural 5 ☐ Pendin	9	oth, Day Year)	28b. Time of Injury		8c. Injury Work			28d. Describe ho	ow intury	occurred		
<u>s</u>	death death ttor:	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be			М		′es 2 □N		20()				
DIVISION	or A lifter Direction by	Certification;	4 Homicide determ	ned 286. Place	e of Intury - At h ing, etc. (Speci	ome, farm, str fy)	eet, factory	, office		1	28f. Location (Si City or Town	treet and n, State)	Number or P	lural Route Nu	m <i>ber</i> ,
_	pital urs erai illed		29a. Certifier 1X Certifyin												
	Hos 24 hc Fun fely	edical	(Check only 2 Medical one)	g Physician: To the Examiner: On the b	asis of examina	owledge, death ation and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, death	i place, a h occurre	and due to the c ed at the time, d	ause(s) ate and	and manner a place, and du	s stated. e to the cause	(s)
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral.	Med	29b. Signature and title of	and man	iner stated.			. License						th, Day, Year)	
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			30. Name and address of person								1 1 0	200=			
	-01		Barry N. Roser 31. Date filed (Month, Day, Year)) Farraş Hegistrar's Signa		. Ker	sing	gton,	Mary	yrand 20	J895			
	Sta Registr			2000	giorai a aighi	H L	roll s								

State

Registrar

me and address of perso

MON

DEC

Month, Day, Year,

6 2006

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(Item 23a) (Typ

Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 Physician 137 Mary December Tice 4:05AM Irene /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Grantsville 1924 Dorsey Hotel Road Garrett If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs. Director Sept.5,1952 Pennsylvania <u>218-88-5410</u> Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Haalth and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23e or 28e-f ahow any injury or other traumatic event, the Medical Evaminar must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Grantsville MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21536 USA 1924 Dorsey Hotel Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0020 Specify. Specify. Be Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Lydia Yoder Lloyd Yoder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1924 Dorsey Hotel Road, Grantsville, Aaron Tice/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2006 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dec.15, Salisbury, PA 4 ☐ Donation 5 ☐ Other (Specify) View Cemetery Mt. 21. Signature of Funeral/Service Lice 22. Name and Address of Facility Home, P.A. Newman Funeral 179 Miller Street, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Metastatie Breast Cancer /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner attending physicien end for use es the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy Be 2 Medical Certification:

the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours aftar deeth.

To the Funeral Director: After this completely filled in by the funeral di

						completion of cause of death?
					1□Yes 2No	1 ☐ Yes 2 ☐ No
5. Was case referred to	medical			26. Place of D	eath (Check only one)	
examiner? 1 ☐ Yes 2 No		Hospital: 1 ☐ Inpatient 2 ☐	☐ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 Residence 6 □Othe	or (Specify)
7. Manner of Death 1 Naturel 5 [2 Accident	Pending investigetion	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurre	ed
3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Injury - At h building, etc. (Speci		ory, office	28f. Location (Street and Number City or Town, Stete)	er or Rural Route Number,
					ce, and due to the cause(s) and mar curred at the time, date and place, a	

D0034231

29b. Signature and title of certifier

4

29c. License number 29d. Date signed (Month, Day, Year)

2006

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

21536 GRANTSVILLE, MD <u>Robin Bissell</u> 124 MAIN STREET, 31. Date filed (Month, Day, Year)

State

Registrar

DHMH 16 Rev 6/95

32. Registrar's Signature 2006

			1 - For State Registrar		Maryland / Dep <i>Ce</i>	artment of l		Re	eg. N2 0 0 6	41169
1	Physici	an	1. Decedent's Name (First, Middle, Las Albert Valente	t)				2. Date of Deat Month	Day Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give Copper Ridge	street and number	or)	Sykesvi			4c. County of Death	
	Funeral Director		170 07 2233	9X 7. / 2 M 2 □ F	Age (In yrs. last birthday) 90 Yrs.	Months Days		1rs. 8. Date of Birth (Month, Day, 3/25/19	Year) 9. Birtl Co. Pen	nplace (State or Foreign Intry) nsylvania
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	Maryl -1 sho	ţō	MD Howard		Ellicot	t City				1 ☐ Yes 2 🙀 No
	or 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	ath wi	rai C	4750 Hallowed Stre			2104			USA	
980	urs after de al', or items Examiner m	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force 127 Yes 2 [If Yes, Give Year or Date:	¬No 1941-	Was Decedent of If Yes, specify Cut		(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify: Whi	, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat the ricillish at ances.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4c	or 5+) (Give	dent's Usual Occu kind of work done DO NOT use retire	during most of a	working	16b. Kind of Business/	•
d 2	filed Hygie other ent,	င် င်	17. Father's Name (First, Middle, Last)	<u>_</u>	1 11191	TICCL	18. Mother's N	lame (First, Middle, I	Westingh Maiden Sumame)	Juse
lan	should be f and Mental I s marked of umatic eve	To Be	Francis A. Valer	nte			Jose	ephine Car	hide	
Maryland	and 2 should be filed withir salth and Mental Hygiene. n 27 is marked other than ier traumatic event, Its M		19a. Informant's Name/Relationship (7 Winifred C. Valer						City or Town, State, Z t City, MD	ip Code) 21042
nore,	Pages 1 and 2 nent of Health int: If item 27 iry or other tru		20a. Method of Disposition 1 Buriai 2 Comment 3		18	matory or other pla			20c. Location - City or atonsville	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen			2. Name and Addr	ess of FacilityHa	arry H. Wi	tzke's Fami icott City	ily FH Inc.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	plications that caus one cause on each	sed the death. Do not en				est,	Approximate Interval Between Onset and Death
ı	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to (or	as a consequence of):					ears
8760,	ate be executed hysician and the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last	с	as a consequence of): as a consequence of):					
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 [at time of death 5 [□Ectopic pregnand □ Other (specify)	¢y		23d. Date of deli Month	very Day Year
	quires that in signed b uld be deta	þ	Part II. Other significant conditions of	ontributing to death	n but not resulting in the t	inderlying cause g	ven in Part I.	23e. Did tob	pacco use contribute lo es 2 No 3 □ Pro	the cause of death?
Division of Vital Records,	The law requirr ate has been si page 2 should t	Completed						24a. Was a autops perform	y prior to d	copsy findings available completion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		0	bor	Death (Check only on		
on of	ling After fune	itlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of li (Month, l		of 28c. Inju		_	ence 6 Other (Spec ow injury occurred	ify)
Divisi	i Cite	Certification:	3 Suicide 6 Could not be determined	286. Place of	Injury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysician: To the be niner: On the basis and manner	st of my knowledge, dea of examination and/or in stated.	th occurred at the to investigation, in my	ime, date and pla opinion, death o	ace, and due to the ca ccurred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier			29c. Licer	se number	2	9d. Date signed (Month	, Day, Year)
			· Wate-111	- MO		Dos	5813	7	12/7/6	
<u>)</u> 0	s		30. Name and address of person who	completed cause of	of death (Item 23a) (Type Stone A	Print)	207	Westerin	ste MO	21157
	Sta Registi		31. Date filed (Month, Day, Year) DEC 0 8 2		strar's Signature	heek ;				

		1	For Stata Registrar	S	State o	of Marylar		artment of I	Health and M Death		iene g. No.2	006	41170
		_	Decedent's Name (First, Middle,	Last)						2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		Kaaron Vaughn							Decembe	-	2006	9:14 P M
	Examin		4a. Facility Name (If not institution,	give stre	eet and nu	mber)		4b. City, Town,	or Location of Death	1	4c. Cou	nty of Death	
П			2400 Honeyston		у				teville	1		gomer	
	Funeral			5. Sex 1 □ M	4 2 X F		. last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day,		Cou	place (State or Foreign intry)
	Director	-	441-72-0760 Usual Residence of Decedent			4	3			Jan 6,	1963	Ok1:	ahoma
	/land	ı	10a. State 10b. County			10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Man	ţ	Maryland Mont	gome	rv	s	ilver S	pring					1 ☐ Yes 2 🛣 No
	h the	Director	10e. Street and Number	O-=-				10f. Zip Code		1	0g. Citizen	of What Cou	intry?
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	hours after deeth with the Maryland tural; or Items 23a or 28a-f show al Examinan mual be notified at	Funeral	11. Marital Status		Armed F	edent Ever in lorces?	U.S. 13.	Was Decedent of f Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White	
9	s afte	by Fi	1 Never Married 2 Marrie 3 Widowed 4 Divorced	ed	1 □ Yes If Yes, G Year or [2 M No		1□Yes 2∏ No	Specify:		Spe	cify:	Black
9500-61212	be filed within 72 hours after deeth with the Marylan ital Hygiene. dother than "natural; or items 23a or 28a-f show a other than "natural; or items 23a or 28a-f show swent. I'm Micalcal Examinar must be notified at	ed t	15. Decedent	s Educa	tion		16a. Dece	dent's Usual Occu	pation		16b. Kind o	f Business/Ir	
C .	within 72 ene. than "na	Completed	(Specify only highes Elementary/Secondary (0-12)	grade d		1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wor ed)	king			
7	d with giene	mo:	Clementary/Secondary (0*12)		College	4	Dep	artment	Manager		Neima	n Marc	cus Stores
9	e file al Hyg l othe vant,	Bec	17. Father's Name (First, Middle, L	ast)					18. Mother's Nan	ne (First, Middle, I	Maiden Sun	name)	
<u>a</u>	Ments Ments arked arics	To	Leo Vaughn, Sr							ah Lee Mo			
Maryiand	2 should be filed won and Mental Hygie Is marked other the	1	19a. Informant's Name/Relationsh						t and Number or Ru				
	permit. Pages 1 and 2 should Department of Heelth and Men Important: If Item 27 Is marke any Injury or other traumatic anse.	ļ	Toian Vaughn/S	iste	r	20h			one Way, I			D 2083 on - City or T	
0	Pages 1 ment of H ant: If its ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		noval from	State		natory or other pla				•	
Baltimore,	then tant:		4 Donation 5 Other (Sp			M		. Park Ce	em Dec . ess of Facility Hir				Oklahoma
g	permit. Pag Department Important: sny Injury o		21. Signature of Funeral Service L	6	ern	00	1:	800 New	Hampshire	e Ave, Si	lver		g, MD 20904
J	Physician	9	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complica only one	tions that cause on	caused the dea each line.			ast Cance		est,		Approximate Interval Between Onset and Death 3 yrs, 5 mos
	/Medical Examiner		resulting in death)		Due to	(or as a conse	equence of):						
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	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
<u> </u>	ate be executed hysicien and the burial-transit	Exa	resulting in death) Last	G.	Due to	(or as a conse	equence of):						
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89	in dig		IF FEMALE:	T									
Box	ires that the death certifical signed by the attending phy d be detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	230	1 Live	utcome of preg birth 2 Fe	tal death 3	⊒Ectopic pregnan	су		23d.	Date of delive	very Day Year
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<u>а</u>	hat th d by detacl	Æ	Part II. Other significant condition	ns contr	ibuting to	death but not re	esulting in the I	inderiving cause o	even in Part I.	23e. Did to	bacco use o	contribute to	the cause of death?
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Vital	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Но	spital:	Inpatient 2	☐ ER/Outpatie	nt 3□ DOA O				Other (Spec	Sister's Mesidence
ō	Phy er this eral c		27. Manner of Death			of Injury nth, Day Yeer)				28d. Describe h			MESTHEILE
<u>o</u>	Attending ir death. ector: After by the fune	atlo	1 XNatural 5 Pendin 2 Accident investig		(1910)	man, Day 1001)	injury		JYes 2 □No				
Division	Atts er des recto by th	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		28e. Plac	e of Injury - At	home, farm, s	reet, factory, office	9	28f. Location (S City or Tow		umber or Ru	ral Route Number,
Ö	rs efter or rain Direction	Cer											
	To the Hospital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the 1	edical			er: On the				time, date and place opinion, death occi				
	ro the within To the comple	Me	29b. Signature and title of certifie	1	T	1 1	0	29c. Licer	nse number	2	29d. Date si	gned (Month	n, Dey, Year)
)	4		· auf	D	H	mu	un,	2	D37236		Decemi	ber 7,	2006
	/		30. Name and address of person	who com	npleted ca	use of death (It	em 23a) (Type	, Print)					
_			Carolyn B. Heno	lric				ledge Dr	, #506, B	ethesda,	MD 2	0817	
*	St. Regist	ate rar	31. Date filed (Month, Day, Year)	8 20	106	Registrar's Sig		bartes					

06-09115 Joseph Vilcek

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) Date of Death Physician/ Joseph (NMN) Vilcek 1522 hrs November 30, 2006 **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number) Calvert Prince Frederick 114 Westlake Blvd Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 6. Sex 5. Social Security Number **Funeral** Foreign Czechos1 Days Hours Director 05/27/1916 90 156-09-0076 $1 \mathbf{X} \mathbf{M}$ 2 ovak1a Usual Residence of Deceden Oc. City, Town or Location 10d Inside City Limits 10b. County 10a State 3DV Prince Frederick Yes 2 X No Calvert MD 28a-f show death with the Maryland 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number or items 23a or 28a must be notified at USA 114 Westlake Blvd. 20678 Funeral 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S White, etc. Armed Forces? 1 Never Married Married Yes 2 X No White Yes 2 X No specify. f Yes, Give Year Specify 3 X Widowed Divorced "natural". ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) 12 should be filed within 72 ho th and Mental Hygiene
127 is marked other than "ns umatic event, the Medical Ex Baltimore, MD 21215-0036 Mechanic Chemical Idustry 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vilcek Anna Be Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) ပ 3175 Tobacco Road Chesapeake Beach, MD Pages I and 2 shoment of Health and lant: If item 27 is or other traumat Christine Harvat (daughter) 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/03/2006 Clinton, MD 20735 Lee Crematory permit Page
Department of Important: Donation 5 Other Specify: 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home Calvert, PA Owings, MD 20736 8125 Southern Maryland Blvd. ary J. Got Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Contact Gunshot Wound of Head Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and ga UNPENDED **AMENDED** attending physician or use as the burial Physician/Medi Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ 1 Yes 2 V No 3 Probably 4 Unknown Completed s been si 24b Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 1 🗸 Yes No After this certificate 26 Place of Death (Check only one) 25. Was case referred to medical Division of Vital the Hospital or Attending Physician: Be Hospital: 1 Other₄ Nursing Home 5 Residence 6 ✔ Other Scene ER/Outpatient 3 DOA Inpatient 2 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred 27. Manner of Death Certification: Subject shot self FOUND within 24 hours after deau.

To the Funeral Director: A Natural 1 Yes 2 V No 5 Pending Nov 30, 2006 1520 hrs 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 114 Westlake Blvd, Prince Frederick, MD determined (Specify) Residence Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b./Signature and title of certifie December 1, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 20 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. 31. Date filed (Month, Day Year, DEC 5 2 Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Nadine Chartier Westphal December 14. 2006 8;00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 □ F Director 225-06-7960 21, 1962 Washington. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10h. County 10d. Inside City Limits r 28a-f show Funeral Director VA Fairfax 1 ☐ Yes 2 ☐ No Herndon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ must be 12868 Whitefur Lane 20170 23a USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Be Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) <u>Instructional Designer</u> Warranty Admin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Menta ္ပ Roland Chartier Virginia Schmidt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Westphal - Husband 12868 Whitefur Lane Herndon, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or oti
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chestnut Grove Cem. 12/20/2006 Herndon, VA 21. Signature of Funeral Service License 22. Name and Address of Facility 721 Elden St. Min Adams-Green Funeral Home Herndon, VA 20170 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA 1 Day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 24 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) Ö م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by pleural effusion, metastatic colon cancer, UTI 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown <u>anemia, pulmonary embolism</u> 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death al or Attending P s after death. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide filled in by 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0060117 December 15, 2006 - MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20

DHMH 17 Rev 1/2001

State

Registrar

Eric J. Park, MD

DEC 26

2006

31. Date filed (Month, Day, Year)

December 14,2000

Mestohal, Nadine

Center Drive

Rockville, MD

9901 Medical

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 7:30 AM **Physician** ETHEL P. WILLIAMSON DECEMBER 5. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🗓 F Yrs 577-18-4919 AUGUST 25, 1915 DISTRICT OF COLUMBI Director 91 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r then "naturel", or iteme 23a or 28a-f ehow the Modical Examinat must be notified at 1 ☐ Yes 2 🛛 No SILVER SPRING MARYLAND MONTGOMERY Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3641 SOUTH LEISURE WORLD BLVD, APT. #2-B 20906 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Baltimore, Maryland 21215-0036 Specify: ģ 3 X Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. GOVERNMENT LEGAL SECRETARY 2 permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked other eny injury or other traumatic access. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SARAH HANIG HUGH LAWRENCE PEDEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROBERT J. PEDEN - NEPHEW 1609 CHARNITA COURT, VIENNA, VIRGINIA 22182 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BRENTWOOD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CREMATORY 12/10/2006 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC.
11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 21. Signature of Funeral Service Licens Nancy 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** hecdays /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ate has been signed by the attending physicien page 2 should be detached for use as the buria by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 2. No Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1. Afripatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes this 28a. Date of Injury (Month, Day Year) ierai Director: After thi 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 Tes 2 No death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hoepital o within 24 hours aft To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

ALOK

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

108

4 YSTCICA

32. Registrar's Signature

4000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATHUIZ

29c. License number

D0055694

MD

Olney,

29d. Date signed (Month, Day, Year)

20832

December 5, 2006

Registrar
DHMH 17 Rev 1/2001

		For			artment of Healt		-	•	1 1 -7 1-6
		1 - For State Registrar			tificate of Dea			NO. UU6	411/5
Physicia	'n	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day o Year	3. Time of Death
/Medic		Thomas Eli Wachter					December		8:10 PM
Examin	er	4a. Facility Name (If not institution, give si			4b. City, Town, or Locat			4c. County of Death	
Funeral		Glade Valley Nursi 5. Social Security Number 6. Sex		yrs. last birthday)	Walkersvi	11e nder 24 Hrs.	8. Date of Birth	Frederi	
Funeral Director		214-16-0406	M 2□F	86 Yrs.	Months Days Hou	urs Min.	July 19,	1920 Mar	place (State or Foreign ntry) 'Yland
pun *		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo					and leader Other Limite
Maryla f sho	٥	Maryland Frederic		Frede					10d. Inside City Limits 1 Yes 2 No
28e	rect	10e. Street and Number	. K	riede	10f. Zip Code		100	. Citizen of What Cou	ntry?
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or fisms 23a or 28e-f show raumatic svent, the Medical Examiner must be notified at	Funeral Director	324 Redwood Avenue			21701			United St	
ems i	ner	11. Marital Status 1	2. Was Decedent Ever Armed Forces?	in U.S. 13. \	Was Decedent of Hispanio f Yes, specify Cuban, Mex	c Origin? (Spe	ecify Yes or No-	14. Race - Ameri Black, White	
s afte	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 XXYes 2 □ No 1 If Yes, Give	943-	1 ☐ Yes 2 ☑ No Spe		,,	Specify: Wh:	
tural	ed b	15. Decedent's Educ	Year or Dates:	1946	lent's Usual Occupation		16	b. Kind of Business/Ir	ndustov
hin 72 9. In "na Medis	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done during : DO NOT use retired)	most of worki	ng	o. 14114 of 54511103511	ladatiy
gentha or tha	Com	12	Conogo (17401 54)		Plumber			Plumbing	
be file of oth	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Ma		
d Men narke	၉	Millard Richard Wa		401 14 75			Irene Ric		
d 2 sl th and th and traur		Dorothy Mae Wachte			ng Address <i>(Street and Nu</i> Redwood Ave.			-	o Code)
f Heal f Heal item 2		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of		ate 20	c. Location - City or T	own, State
Page not: If iry or		1 ☐ Burial 2 ※ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		-	natory or other place) n Crematory		mber 8,	ederick,	Maruland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show sny Injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Fundal Service License			Name and Address of Fi Sthaven Fund				
20E # 9		1063		95	Ul Catoctin	Mtn.	Hwy. Fred	erick, MD	
		snock, or near failure. List only one	flions that caused the cause on each line.	death. Do not ente	er the mode of dying, such	h as cardiac o	or respiratory arrest		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ Conge	5+1VE	head ta	dure			2-3 WEPK
Examiner			Due to (or as a cor	sequence of):					
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nding use a	N/Me	IF FEMALE: 23b. Was decedent pregnant	ic. If yes, outcome of pre					23d. Date of deliv	Brv
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w requires that the death certificate be executed been signed by the attending physicien end should be detached for use as the burial-transit	Completed by Physician/Med	Part II. Other significant conditions cont	0	resulting in the ur	nderlying cause given in P	art I.	23e. Did tobac	co use contribute to t	
need plant	eted	- pulmonary	Floresis						
hes ge 2 :	m I						24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
un: T	ပို	25. Was case referred to medical				Nace of Death	1	No 1 ☐ Yes	2 No -
ysich is cer direct	To B	examiner?	ospital:	2 ER/Outpatien	Oak -	1	me 5 ☐ Residenc	e 6 □Other (Speci	(ن
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tendi Jeath. tor: A the fu	cati	2 Accident investigation 3 Suicide 5 Could not be	-		M 1 ☐ Yes 2				
or At efter of Direc	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (SA	At home, farm, stre <i>ecify)</i>	eet, factory, office	2	28f. Location (Stree City or Town, S	t and Number or Ruri State)	al Route Number,
spital		29a. Certifying Physi	nian: To the best of my	kriuwledge, deeth	Secured at the time, date	e and place, a	and dua to the eaus	ofa) and wann eras s	tato i
To the Hospital or Attending Physician: The law requires that the death certifice within 24 hours efter death. To the Funersi Director: After this certificate hes been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Examination)	er: On the basis of exar and manner stated.	nination and/or inv	restigation, in my opinion,	death occurre	ed at the time, date	and place, and due to	o the cause(s)
To t	Σ	29b. Signature and title of certifler			29c. License numb			Date signed (Month,	Day, Year)
MI		AAAA	- Hi	zon of 5	hah Ds	1643		12/7/06	
1211		30. Name and address of person who con	npleted cause of death	(Item 23a) (Type,	Print)	121		112-0	
Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature _	LEGE	n 0/15	MD	14402	
Registra	_	DEC 0 8 20	Ub Balus	D. A	assi				

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Ragistrar	State of Ma	ryland / Depa <i>Cel</i>	artment of tificate o		nd Mental I	Hygienę Reg. Né	2006	76
ı	Physici		1. Decedent's Name <i>(First, Middle, Las</i> Virginia Wei	•				2. Date o Month 12			3. Time of Death 2:30 P M
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of			County of De	
			1110 Healthway Dr.	, Apt 142		Salisb	ury		Tai	licomic.	0
	Funeral Director		030-01-3983	TH OFF	(In yrs. last birthday) 7 Yrs.	Months Day		4 Hrs. 8. Date o (Month	f Birth , <i>Day, Year)</i>	9. B	inthplace (State or Foreign Country) ichagan
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Mary I eh	to	MD Wicomico	,	Salisbu	rv					Y Yes 2 □ No
	th the	Funeral Director	10e. Street and Number	1.		10f. Zip Code	•		10g. Cit	izen of What (Country?
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	er dez	une	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of Yes, specify Ci	f Hispanic Origi uban, Mexican,	in? (Specify Yes o Puerto Rican, etc.	r No-	14. Race - Am Black, Wh	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 ie marked other than "naturel; or Iteme 23a or 28a-f ehow any Injury or other traumatic event, I'te Medical Examinar must be notified at once.	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X☐ No If Yes, Give Year or Dates:		1 □ Yes 24OXN	lo Specity:			Specify: W	nite
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Division of Vital	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2.	tlon: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 Inpatient 28a. Date of Injury (Month, Day)	2 ER/Outpatier 28b. Time of Injury	28c. In		28d. Descr	Residence ibe how injur		ecity) A45 i Al ALI VI
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	To t To t	ž	29b. Signature and title of certifier			29c. Lice	nse number		1	-	nth, Day, Year)
			Jenney Pros	W_	MB		3201	4	12/	6/06.	
	BA 10		30. Name and address of person who come Manager Manager Model	ompleted cause of dea	ath (Item 23a) (Type, M) IFAV	Print) 1 St 5	64B 9	salisbue	vy an	D 21:	804.
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 7 20	32. Jegistrar	's Signature	rede					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 6, 2006 **Physician** George Raymond Wallrodt 7:05 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 20 Brookes Avenue Gaithersburg Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 26, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Min. 72 Yrs. Director 577-44-4442 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Gaithersburg Montgomery Director 1 Tx Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Brookes Avenue 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No δ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
United States Depart. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Education Deputy Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Wallrodt Frances Henkel ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Willoughby/ Partner 20 Brookes Avenue, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cametery, crematory or other p Dec. 7 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2006 Alexandria, Virginia 4 Donation 5 Dother (Specify) Licensee 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock of heart failure. List only one cause on each line. Cirrhosis of the Liver Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached 1 9☐Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been si , page 2 should t 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an . Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performe 1∐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 🗀 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural thours after death.

-uneral Director: A
ely filled in by the fu death. 1 Tes 2 □ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000646 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

2006

Genevieve Wroblewski, M.D., 1355 Piccard Drive, Suite 100, Rockville, MD 20850 32. Registrar's Signature

			1 - For State Registrar	State of Ma	arylan				lealth a Death	and Me	ental Hy	giene Reg. No.	00	5	Marriago de Cartes de Cart	78
			1. Decedent's Name (First, Middle, Last)								2. Date of D		,	/	3. Time of	f Death
	Physici /Medio		Florence Carol	yn Wagn	er					C	Month ecembe	r 6,	2006	/ear	2:05	рм
	Examir		4a. Facility Name (If not institution, give s	street and number)			4b. City	, Town, or	Location o	of Death	-	4c.	County of	Death	-	
			3002 Plyers Mill	Road				singt				M	ontg	omer	У	
	Funeral Director		5. Social Security Number 6. Sex 579−34−6405	7. Age	e (In yrs. I 77	last birthday) Yrs.	If Unde Months	Days	If Under a	Min.	8. Date of Bi (Month, D lug • 29	ay, Year)		Coun	lace (State ontry) York	or Foreign
	pu *		Usual Residence of Decedent 10a. State 10b. County		100 Cib	y, Town or Lo										
	anyla eho	<u>_</u>	Too. State		100. 011	y, rowirdi co	Cation							1	0d. Inside C	2K□ No
	Ne M	Director	Maryland Montgome 10e. Street and Number	ry		Ken	sing									26 140
	with			D 1			101. 2	ip Code					zen of Wh	iat Coun	itry?	
	eath	era	3002 Plyers Mill	12. Was Decedent B	Euge in t1	6 12.1	Man Dan	2089					USA	Amaria	an Indian.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other treumatic event, its Madicial Examinar must be notified at ance.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:			fYes, sp	ecify Cuba 2 🛣 No	n, Mexican Specify:	i, Puerto R	cify Yes or Ni Rican, etc.)	0-		White,	etc.	
ğ	2 hou	ed	15. Decedent's Educ	cation		16a. Deced	lent's Us	ual Occupa	ation			16b. Kir	nd of Busi	ness/inc	dustry	
215	7 nin 7.	Completed	(Specify only highest grade	College (1-4or 5		(Giva	kind of w	ork done d use retired	turina most	of workin	g					
2	d with	E O	10	College (1-401 5	+)	Sec	reta	ry				Cler	ical			
ğ	otha otha	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)			
<u>a</u>	Aenta Aenta rked tlc e	ToE	Harold Rudolph Bu	rdett						Jean	R. Mo	Pher	son			
Maryland 21215-0036	and h		19a. Informant's Name/Relationship (Typ								Route Numb					
	and ealth m 27		Curtis H. Harrison	/ Son					Court,	, Dam	ascus	, Mar	yland	1 20	872	
Baltimore,	Tite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	emoval from State	20b. P	lace of Dispo emetery, cren	sition (Na natory or	ime of other plac	e) r	Da	ber 7,		cation - Ci	ity or To	wn, State	
Ē	Fant:		4 □ Donation 5 □ Other (Specify)		Metr	copolita	n Cre	matory	_ _	20			andri	La,	Virgir	nia
39	Depar Depar Impor any In		21. Signature of Funeral Service License			22 F	ranc	ad Addres	s of Facility	lins	Funera					
_	40 5 e d		Michel	Hole							, W, S		r Spi	ring	, MD	20901
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comiliation shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Ause on each lin Hyperten Due to (or as a Chronic Due to (or as a Due to (or a) Due to (e. Ision a consequ Obtr	uence of): uctive						ATT GSG,			Approximat Interval Bet Onset and I	ween
P.O. Box 68760,	The law requires that the death certificate be executed tie hes been signed by the attending physicien and page 2 should be detached for use as the burial transit	by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of the control o	2 Fetal	death 3	Ectopic p	oregnancy pecify)				2	3d. Date o		-	Year
	es tha igned I be det	y P	Part II. Other significant conditions conf	tributing to death bu	it not resu	ulting in the un	derlying	cause give	n in Part I.		23e. Did	tobacco u	se contrib	ute to the	e cause of d	leath?
ğ	w require been sig should b	edt	Dementia								10	Yes 2	No 3	☐ Proba	ably 4 ⊠t	Jnknown
Records ,	aw re	Completed									24a. Was	an	24b. We	re autop	sy findings a	available
	hysician: The law his certificate hes t I director, page 2 s	E										ormed? 2½ No	dea	or to con th?]Yes ::		ause or
Vital	ian: rrtifica ctor,	Be	25. Was case referred to medical examiner?						26. Place	of Death	Check only			, 103	2010	
	Physic this ce el dire	2	1 ☐ Yes 2½ No	ospital: 1 🔲 Inpatier	nt 2 🗆 E	ER/Outpatient	3 🗆 D	OA Othe	r: 4□ Nur	sing Hom	e 5∕⊡Resi	idence 6	Other	(Specify	•)	
0	ding Ph h. After th funerel		27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury		28c. Injury Work	_		d. Describe					
Š	Attendir death. ctor: Al y the fu	atle	2 ☐ Accident investigation	(,		,,	М		res 2 □ N	10						
DIVISION OF	tal or Attendestrics after destrictor:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ry - At ho	me, farm, stre	et, factor	y, office		28	Bf. Location (City or To	Street and wn, State)	Number	or Rural	Route Num.	ber.
	To the Hospital or Attending Physician: within 42 hours after death. To the Funderel Director: After this certific completely filled in by the funerel director,	Medical	29a. Certifier Check only one) Certifying Physical Cartifying Phys	ician: To the best of er: On the basis of and manner sta	examinati	Medga death ion and/or inv	ochumac estigation	at the time i, in my op	date and inion, death	l place, an	d due to the d at the time,	date and	and mann place, and	of as sta due to	the cause(s)
	To To E	Σ	29b. Signature and title of certifier	D			- 1	c. License	- 00	757	7		-		Day, Year)	
	12		Pice Of !!	8				0	6 03°	173	2	D	cun	n be	~ 7, 3	2006
	10		30. Name and address of person who cor	mpleted cause of de	eath (Item	23a) (Type, F	Print) リ・モ	din	ons t	on !	Dr. #	200	Po	Ckr	1.16,1	ND
	Sta Registr		31. Date filed (Month, Day, Year) PEC - 8 2001	32. Registra			400									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dorothy M. Amendolair Watson 2:00 P. December 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 4465 Lancaster Drive Leonard Year If Under 24 Hrs. If Under 1 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Funeral 1920 Months Days Hours 1 □ M 2√2 F 4, Washington, DC Apr. 578-14-8126 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □Yes 2√No Director Calvert St. Leonard Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20685 United States by Funeral 4465 Lancaster Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 3 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🗶 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Computer Programer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis White Margaret Norton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donn Amendolair (Son) 1735 Twirly Court, Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 12/20/06 | Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** End Vine disease or condition resulting in death) Due to (or as a consequence of /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 ponths? 1 ☐ Yes 2 ☐ No 3 DEctopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 No 1 ☐ Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performe certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) this 28b. Time of 27. Manuar of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after uca....

To the Funeral Director; After any After in the funeral pile in by the funeral pile in the fune

> State Registrar

Kioumarce Yazdani, MD 2555 Solomons Island Road, Huntingtown, Maryland 20639

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Laumarc

29a. Certifier

(Check only one)

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEC 6 2006



1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

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6-09391 dward Dewitt W	Jilbi		oe or Print i							egibl	e.		
dward Dewill V		1- For State	ate or iviaryi		rtificate o		anu	wentai i i	ygierie	Reg. No	20	0.6	1.110
Physicia		Registrar 1. Decedent's Name (First, Midd	le,Last)						2. Date of D	eath	-	3	. Time of Death
Medical Exami		Edward DeWitt	Wilburn						Month Decemb				1716 hrs
. مغر ز		4a. Facility Name (if not institution Garrett Memorial Hos		umber)		4b. City, Tow		cation of Death	1	- 1	c. County of t Garrett	Death	
Funeral		Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1		If Under 24Hrs	s. 8. Date of	Birth (MN			place (State or
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death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	577 Hoyes Rd.				2154				US			
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5-0036 led within 72 hours after di Hygiene other than "natural", or the Medical Examiner m	ক্র	3 Widowed 4 Div	vorced If Yes, Give Ye or Dates:		16a Decede	Yes 2 X		specify: n (Give kind of	work done	16h	Specify: W		
2 hour	ited	Elementary/Secondary (0-12)		1-4 or 5+)				O NOT use ret		100.	Kind of Busin	1033/11/0	iden y
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215-0036 be filed within 72 hours after death with the Maryland nual Hygiene, rked other than "natural", or items 23a or 28a-f shent, the Medical Examiner must be notified at once		17. Father's Name (First, Middle				_		Mother's Name			n Surname)		
21215-0036 ould be filed within 7 4 Mental Hygiene s marked other than ie event, the Medica	o Be	Merrill E. Wi. 19a. Informant's Name/Relations			19b Mailir	no Address (larriet			City or Town	State 7	(in Code)
MD 2 rd 2 shou lith and M m 27 is n	F	Betty B. Wilbu						McHenr		215			
imore, MD 21; Pages I and 2 should b nent of Health and Men tant: If item 27 is mar or other traumatic eve		20a Method of Disposition 1 X Burial 2 Cremation			Place of Dispo		of ceme	etery,	Date	200	. Location - C	ity or To	own, State
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Baltimore, permit Pages I ar Department of Hee Important: If ite injury or other tr	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, F												P.A.
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Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	3 Suicide 6 Cou	ald not be 2Be. Pla	ce of Injury - At I	home, farm, str	eet, factory, o	ffice bui	lding, etc.		n (Street n, State)	and Number	or Rura	Route Number, City
Di ospital hours a meral 1		4 Homicide	ermined (Specify		d				d di			1-1	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only Certifying F	Physician: To the be aminer: On the basis	of examination									
To wit	Me	29b. Signature and title of certif	and manner	stated		29c. L	icense	number		290	. Date signed	(Monti	h, Day, Year)
		XIKA	$\times w$				O.C.M	.E.		De	cember 1	0, 200	06
		30. Name and address of perso				nn Chrt	Dolt:	nore MD 2	1201	1	•		
		Susan Hogan MD. 31 Date filed (Month, Day Year	Assistant Med	cal Examine Registrar's Signa		onn Street,	Daitir	nore, MD 2	1201				
Regis	tate trar	31 Date filed (Month, Day, Year	2006	alpea e	M. And	1 a M. 3							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year December 7, 2006 Esther Wilt 7:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Oakland Nursing and Rehab Center 0akland Garrett If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)

June 22, 1930

9. Birthplace (State or Foreig Country)

West Virginia Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 👿 F Days 76 Director 236-50-0654 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Itams 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Completed by Funeral Director Garrett Swanton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3357 Swanton Road 21561 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Poultry Processing Processor 8 other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liury or other traumatic event ouse. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Early Arnold Elsie Walter Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 3000, Swanton, Maryland Eugene E. Wilt/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Accident Cemetery 12/10/06 Horse Shoe Run, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland, ND LN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician disease or condition resulting in death) oyear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknowl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has page 2 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medicai Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation death, neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) within 2 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kauser us 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

06-09361	
Orlando Amaya	

Orlando Amaya		State of Maryland / Department 1- For State Certificate			g. No. 2006	5 4118				
Physicia	an/	1. Decedent's Name (First, Middle,Last)	-	Date of Death Month	9.110.	3 Time of Death				
Viedical Exami	ner	Orlando Amaya 4a Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	December	8, 2006	0924 hrs				
		Holy Cross Hospital	Silver Spring		Montgomery					
Funeral Director			Months Days Hours Min		(MM/DD/YYYY) 9. Birtl Foreign Cou					
any		Usual Residence of Decedent 10a State 10b County 10c City, Town or Lo	cation			10d Inside City Limits				
ž .	ř	MD Montgomery Whe	aton			1 Yes 2 X No				
Maryland r 28a-f show ed at once.	Director	10e. Street and Number	10f. Zip Code	ĺ	g Citizen of What Coun	try?				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene? I see marked other than "natural", or items 23a or 28a-f sho raite event, the Medical Examiner must be notified at once.	Funeral Di		2085 Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	USA 14. Race - Americ White, etc.	can Indian, Black,				
er deat		1 Yes 2 No		exican	Specify:	white				
ours aft atural" amine	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	dent's Usual Occupation (Give kind of v	work donaunk						
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene taut. If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during unk	g most of working life. DO N OT use reti	ired)						
21215-0036 uld be filed within 7 Menal Hygiene marked other than c event, the Medica		17. Father's Name (First, Middle, Last)	unk 18.Mother's Name	First, Middle, M	aiden Surname)	unk				
21215 21215 July be file Mental H marked of	o Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	lling Address (Street and Number or F	Rural Pouta Numb	per City or Town State	Zin Codo)				
ore, MD 2 jes I and 2 shoul of Health and In If item 27 is in ther traumatic		O.C.M.E. 111	Penn Street Balt			Zip Code)				
nore, MI ages I and 2.9 nt of Health a t: If item 27 other traum		1 Burial 2 Cremation 3 Removal from State crematory or	position (Name of cemetery, other place)	Date	20c Location - City or 1	rown, State				
Baltimore, permit Pages an Department of Hea Important: If iter	Ì	4 Donation 5 X Othe Specify: in state 21. Jugactus of Funeral Solvice Licensee Ronald S. Wade, Virgotor S.	2. Name and Address of Facility Late Anatomy Board	1 655 W.	Baltimore	Street				
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	altimore MD 2120)]		Approximate Interval				
/Medical Examiner		Nature. List only one cause on each line. Immediate Cause (Final disease a. Chronic alcoholism comp	licated by hypothermia	a		Between Onset and Death				
		or condition resulting in death) Due to (or as a consequence of):								
~~/	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause								
_ :	Examiner	Cisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	al E	d wenter								
60, ate be e hysiciar e burial	Medical	IF FEMALE: AMENDED #23a,PII,27,28a- 23c. If yes, outcome of pregnancy	f, perME, g863, 1/31/0	07 TT	23d Date of delivery					
687 certifica iding pl	ian/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Date of death 2 Fetal death 3 December 2 Fetal death 3 December 2 Fetal death 3 December 2 Fetal death 3 December 2 Fetal death 3 December 2 Fetal death 3 December 2 Fetal death 3 December 2 Fetal death 3 December 3								
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)							
, P.O. Boy res that the death signed by the att	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	, -		pacco use contribute to the					
IS, P quires t en sign	ted b	Remote cerebral contusion of unknown etiol	ogy	1 Yes		ably 4 Unknown				
Division of Vital Records, rate tall or Attending Physician: The law requirers after death at Director: After this certificate has been sited in by the funeral director, page 2 should the	Completed			autops perforn	y prior to co	opsy findings available ompletion of cause of				
tal Rec rian: The l certificate l ector, page		25. Was case referred to medical	26. Place of Death (Check	1 Yes 2	No 1 ✓ Yes	s 2 No				
ion of Vital I tending Physician: eath or: After this certifi the funeral director,	e Be	examiner?	I Othor	p	tesidence 6 Other:					
1 of Vit Jing Physic After this	L.	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Death 1 Natural 5 Death 28b. Time of			ow injury occurred					
Sion Attender Treath Treath Treath Treath Treath Treath Treath	catic	2 Accident Investigation Fnd 12/8/2006 Fnd 8:		unknown	reet and Number or Pur	al Poute Number City				
Divising spital or At tours after dineral Direct filled in by	Certification:	4 Homicide determined (Specify) found in stree		or Town, Sta Wheaton, I	reet and Number or Rur ate) 12109 Grand MD	view Dr.				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – trans	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.								
F % F 5	ž	29b. Signature and title of certifier	29c License number		29d Date signed (Mont					
		tatricia Gronica Tollah m	O.C.M.E.		December 9, 2006	5				
		Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimor	e, MD 21201						
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	coall &							
DHMH 17 Rev 1/20		ORIGIN	IAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Shirley Month **Physician** 22 32 M. Anderson De(2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner HCSPital Cl Baltmare If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** 212-60-8763 1 ☐ M 2 🛣 F Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1XYes 2□No **Funeral Director** Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AUR 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1XNever Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify Completed by Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 7 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse 1 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland To Be t and 2 should be f Health and Mental Anderson more 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Pramble wood Road Pultimore MD position (Name of 20c. Location - C Shannon Hnderson 20a. Method of Disposition Daughter Important: If item 2 any Injury or other once. 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town State 1 Burial 2 □ Cremation 3 □ Removal from State Dutus 12.30.20012 Bultimore, MD 22. Name and Address of Facility Voughn C. Greene Juneral geroice 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 728 Liberty Boad Brondallsteen MO 21133 Immediate Cause (Final Brain Physician hesmaller disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner netastasim Sequentially list conditions, Examiner if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last A pile death certificate be executed Due to (or as a consequence of): burialattending physician for use as the hirial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) Ö signed by the a 9 Unknown <u>ت</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has page 2 s performed certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation within 24 hours after dearn.

To the Funeral Director: After the funeral of the f 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-COC

State

DHMH 17 Rev 1/2001

HAMED

n.p 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MITMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1450 DM **Physician** December 2006 ALICE LOUISE BURKE 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HAVRE DE GRACE HARFORD CO HARFORD MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, JAN. 27 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 73 MARYLAND Director 216-28-6721 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehov other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No ABERDEEN HARFORD CO MARYLAND Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Items 23a or U.S.A. 21001 514 LAW STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2XX\0 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2€XNo Specify: White þ 3% Widowed 4 ☐ Divorced "naturel" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) N/A HOUSEWIFE 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROSE BALDWIN HOWARD BALDWIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Timothy W. Burke/Son 46 Crossfoot Dr., Northeast, Md., 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-29-06 GARRISON FOREST OWINGS MILLS, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 Valer First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien; The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4☐ Pregnant at time of death 5 ☐ Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No certificate 1 ☐ Yes 2 No 1 Yes To the Hospitat or Attending Physicien; within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spearly) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) DEC 2 7 2

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

ee

29c. License number

Revolution St

D2066

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Marylan			of Health and of Death	Mental Hy	giene Reg. No. 2006	41185			
5	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last Zella M. Bennett Aa. Facility Name (If not institution, give			4b. City, T	own, or Location of De		Day Year er 4, 2006 4c. County of Dea	3. Time of Death 6:58 PM M			
	Funeral Director		50 Appeal Lane #55. Social Security Number 6. S 432–58–2420 Usual Residence of Decedent			If Under 1 Months	Lusby Year If Under 24 H Days Hours M		Calvert Th	thplace (State or Foreign buntry) SSISSIPPI			
	the Maryland 286-f ehow notified at	ctor	10a. State 10b. County MD Calve		10d. Inside City Limits 1 ☐ Yes 2 ☐ No								
36	filed within 72 hours after death with the Maryland Hygiene. yther then "naturel", or liems 23a or 28e-f ehow yth, it is Mydical Examinar must be mailisid at	by Funeral Director	10e. Street and Number 50 Appeal Lane #: 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	208 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	ŀ	Nas Decede f Yes, specif	20657 ent of Hispanic Origin? fy Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	10g. Citizen of What Country? USA o-				
Baltimore, Maryland 21215-0035 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or any injury or other treumatic event, the Mudical Exampage.	Completed t	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation	(Give	DO NOT use	done during most of v	working	16b. Kind of Business	/Industry				
	To Be Co	17. Father's Name (First, Middle, Last) Charles Earl R	Navy recruit center Navy recruit center										
	of Health of Hem 27 is		19a. Informant's Name/Relationship (1) Deborah Funchio 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	n/daughter		20 McG	Cready Road		er, City or Town, State, MD 20657 20c. Location - City or				
	permit. Pag Department Importent: It any injury o		4 Donation 5 Other (Specify 21. Sign rure of Eureral Service Licen Onald S)	: <u> S</u> t	ate A	Address of Facility natomy Boa re, MD 21	rd 655 W.	Baltimore	Street			
3. j	Physician /Medical Examiner		23a. Ran1. Enter the disease, or community of the communi	a. CHRONIC Due to (or as a consequence)	Do not ent	er the mode	of dying, such as card	iac or respiratory a		Approximate Interval Between Onset and Death			
760,	be executed ician and burial-transit	Ical Examiner	Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consequence of). c. — Due to (or as a consequence of): d.									
O. Box 68	death certifica a attending ph od for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	23d. Date of de Month	livery Day Year							
1	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions of NYPERTENS		ulting in the u	nderlying ca	use given in Part I.	12		o the cause of death? robably 4 □Unknown			
of Vital Records,		e Completed	25. Was case referred to medical				26. Place of D		psy prior to death? 2 No 1 Yes	utopsy findings available completion of cause of			
on of V	ng Phy Iter this neral d	tlon: To B	examiner? 1 Yes 2 No 27. Manner of Death 1-Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Other	Home 5 Res	dence 6 Other (Spe	ocify)			
Division	spital or Attendii ours after daath. herel Director: A filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify		City or To	Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital within 24 hours a To the Funerei I completely filled	Medical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 2. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due on the cause(s) and manner as 2. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as 2. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as 2. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as 2. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as 2. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as 2. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as 2. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as 2. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the caus										
	To wit		29b. Signature and vitle of certifier	m M)	2	License number (1997) 40370		29d. Date signed (Mont				
			30. Name and address of person who Peter Leonar	d Wisniewski	Princ		derick,MD.	20678					
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa		20 82 1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** Jean Carol Baxter 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salusyny Wicamico PENINSYLA REGIONAL If Under 1 Year | If Under 8. Date of Birth (Month, Day, Dec 29, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F 73 Director 213–28–7682 1932 Md. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worcester Berlin 1 ☐ Yes 2 X No Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 USA 37 Nottingham Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical **MVA** 12 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Glassman Frederick Brothers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 37 Nottingham Lane Berlin Md. 21811 Carson Baxter husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Bayview Crematory 5 ☐ Other (Specify) 2006 Baltimore 4 □ Donation heral Service Connelly Funeral Home of Dundalk WE 7110 Sollers pOint Rd. 21222 23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. not enter the mode of a ing, such as cardiac or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-trai Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) been signed by the s should be detached 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ELM8 Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has be irector, page 2 s autopsy performed? death? 1 ☐ Yes 1∐ Yes 2□ No 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ို 1-patient this funeral 27. Manner of D. th 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Afatural 2 ☐ Accident 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760 filled in by the Director within 24 hours a

To the Funeral I

completely filled

Certification: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 C ttl ving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day Year) nature nd title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

State Registrar

31. Date filed (Month, Day, Year)

DEC

DHMH 17 Rev 1/2001

100 E CARROLL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11147 / perill 304 2/2/07 k5
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Blachowicz December 23,2000 Month Hothony 340 AM 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number), 4c. County of Death Baltimore
If Under 1 Year If Under 24 Hrs. Johns Hopkins Łayview Medical Conter N/A 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 1(**X**M 2□ F 73- 75 Yrs. 213-28-2304 1931 Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore 1 ☐ Yes 2 No Edgemere 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2432 Lodge Farm Rd. 21219 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 ♥ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 11 yrs. Forman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Joseph Blachowicz Nina Punte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) son Anthony T. Blachowicz Jr. 10320 Sussex Rd. ocean city Md. 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 29 2006 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore St. Stanislaus Cem. 4 □ Donation 5 □ Other (Specify) 21. Signature Juneral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Dun 7110 Sollers Point Rd, 21222 Dundalk 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA 5 DAYS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy tindings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Vatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Z Certifying Physician: To the best of my knowledge, daeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

and plant The law requires that the death certificate be executed burial-transit Box 68760, attending physicien the as use ned by the atter o Records, P. sete hes been signale page 2 should b Division of Vital To the Hospital or Attending Physicien; within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

Physician

/Medical

Examiner

Funeral

Director

r then "naturel", or Iteme 23a or 28a-f ehow the Medical Examination must be coulded at

within 72 hours after

al Hygiene.

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Depertment of Health ar Important; if item 27 le eny injury or other treu once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Direct

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Completed

Be

Examine

Physician/Medical

Completed by

Medicai Certification; To Be

State

Registrar

31. Date filed (Month, Day, Year) DEC 2 2006

EATTERN

4940



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Doctor

BALTIMORE MARYLAND

RES- 000

December 23, 2006

tis Samuel Bowr		State of Maryland / Department of Health and Mental Hy - For State Certificate of Death		No. 21	106 1.1100					
Physician		egistrar I. Decedent's Name (First, Middle,Last)	Reg 2. Date of Death	1000	3. Time of Death					
ledical Examine		Otis Samuel Bowman	Month December 2	23, 2006 ^{Yea}	1612 hrs					
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County o						
		Southern Maryland Hospital Center Clinton 5 Social Security Number 6 Sex 17. Age (In vrs. last birthday) If Under 1 Year I if Under 24Hrs	B. Date of Birth	Prince G						
Funeral Director		72 AA 0.791 Months Days Hours Min			Foreign VA					
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Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of Wh						
th the Maryland 23a or 28a-f sho notified at once.		3528 Minnesota Ave SE 20019		USA	7					
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21215-0036 uld be filed within 72 hou Mental Hygiene marked other than "nat	a P	Willie Bowman Joseph 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			ddock					
	۱_	Vernell Monroe/ Daughter 14580 Carrington I								
e, P and Healt Healt fitem	1	20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Riverdale Pk. Crem. 12-			City or Town, State					
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Baltimore, permit Pages I ar Department of Hee Important: If ite	Ī	4 Donation 5 Other Specify 21.,8fgnature of Funeral Service Licensee 22. Name and Address of Facility Tay								
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Physician /Medical	ľ	failure. List only one cause on each line.	respiratory arres	st, Stilock, of the	Between Onset and Death					
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		Sequentially list conditions, b.								
	<u>i</u>	if any, leading to immediate Due to (or as a consequence of):								
g 20 g		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
		d. UNPENDED AMENDED								
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Box 6876 ne death certificate the attending physhed for use as the	Sici	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown								
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of Vital Records, ing Physician: The law require After this certificate has been si funeral director, page 2 should be	۲	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurr	red					
Division tal or Attendi rs after death. al Director: A	Certification	1 V Natural 5 Pending 2 Accident Investigation								
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Divis Hospital or A 24 hours after Funeral Dire	determined (Specify) 4 Homicide 29a Certifier a Countries Device to Device the Provincing Section of the Countries of the C									
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for upon placed.	Medical	one) Certifying Physician: To the basis of my knowledge, death occurred at the time, date and piece, and piec								
and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mor										
	O.C.M.E. December 24, 20									
	1	30. Name and or dress of person who impleted cause of death (Item 23a)								
5	Î	Mary G Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, M	/ID 21201		17					
Sta	_	31. Date filed (MDPT) Cave Year) 2006 32. Registrar's Signature								
Regist	СIJ	A								

06-09839	Please Type or Print in Black Indelible State of Maryland / Department		
	1- For State Certificate	of Death	Reg. No. 2006 4 189
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	l Me	onth Day Year 2156 hrs
()	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
()	2926 Silverhill Ave 5 Social Security Number	Baltimore If Under 1 Year If Under 24Hrs. 8. [Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	219 98.3703 1XM 2 F 3'7	Months Days Hours Min	2-12-1969 Foreign Country) MD
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation	10d. Inside City Limits
8 .	MD ba	ltimore	1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
with the s 23a o e notifi ral D	3123Nortimer Ave 11, Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify	Yes or No- 14. Race - American Indian, Black,
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)	ailing Address (Street and Number or Rural	R ute Number, City or Town, State, Zip Code)
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Baltimore, MD bernit, Pages I and 2 sh bepartment of Health and important: If item 27 is nijury or other traumat		sposition (Name of cemetery, Date of other place)	200. Education - Oily of Town, otale
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To with To	and manner stated 29b. Signature and title of certifier	29c. License number	29d Date signed (Month, Day, Year)
	my hu, mit	O.C.M.E.	December 25, 2006
7	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 21201	
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Physicia		Registrar 1. Decedent's Name (First, Midd	dle,Last)		Timodic or			12	Re 2. Date of Deat	g. No. 2	3. Time of Death		
Medical Exami		Annette Yvette							Month December	Day Year 19, 2006	0935 hrs		
		4a. Facility Name (if not instituti	on, give street and nu	umber)		b. City, Town,	or Location	of Death		4c. County of	Death		
		729 Fremont Avenue				Baltimore							
Funeral	П	5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Y		er 24Hrs.	8 Date of Birt		Birthplace (State or Foreign		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, th. Medis II Examiner must be notified at once.		Birette Young /	Sister	Lea						e, Marylan			
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Page Page nent (Ì	4 Donation 5 Other 5			tro Crema	tory		12/26	5/2006	Baltimore	. Maryland		
alti rmit. epartr nport	Ī	21. Signature of Funeral Servic	V .		22. N	ame and Addre	ess of Facilit			al Home, P			
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Divisior Hospital or Attend 24 hours after death Funeral Director:		29a. Certifier	Physician: To the be		dge death occur	red at the time	date and pl						
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To To	ğ	29b. Signature and title of certification	and manner fier	stated		29c. Lice	ense number			29d. Date signed	(Month, Day, Year)		
		higher	, mo			0.0	C.M.E.			December 20, 2006			
		30. Name and address of person	on who completed cau	use of death (Iten	n 23a)								
2			ant Medical Exa		Penn Stree	t, Baltimore	e, MD 212	201					
	tate	31. Date filed (Month, Day, Year		egistrar's Signat	ure Ara	Me)							
Regis	trar	nec 2	7 2006	and the hours	The state of the s	Partie							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 23, 2006 **Physician** BELOTSERKOVSKAYA 7:30 P M SIMA /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner FUTURECARE CHERRYWOOD REISTERSTOWN BALTIMORE 8. Date of Birth (Month, Day, Year) 08/20/1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral Days Months Hours 220-31-6012 83 RUSSIA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ¥Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3601 FORDS LANE #204 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or iter any Injury or other traumatic event, the Medical Examiner. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No þ Specify Specify. WHITE 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **TEACHER EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ISRAEL DORFMAN **TSILYA** (UNKNOWN) ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 SUNNY MEADOW LANE - REISTERSTOWN, MD 21136 GENNADY BELOTSERKOVSKY / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State HAR SINAI CEMETERY 12/26/2006 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Alzheimer's Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the aid be detached for 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hrknown Completed Coronary Artery 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Naren L. Babrett, M.D. DO058676 December 25, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Main Street, suite 200 Reisterstown, MD 21136 L. babitt MID. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

06-09429	
James Creton	

ames Creton		State of Maryland / Department of Health and Mental Hyglene 1- For State Certificate of Death Reg. No. 2006 4 19
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,Last) James Creton 2. Date of Death Month Day Year December 10, 2006 3. Time of Death 2249 hrs
, Mr.		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Funeral		Johns Hopkins Hospital 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or tink)
Director		Usual Residence of Decedent 48 Yrs. Months Days Hours Min. Sept 10, 1958 Foreign Country)
v any		10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits
Maryland 28a-f show d at once.	tor	MD Baltimore 10g. Citizen of What Country?
0036 within 72 hours after death with the Maryland giene rer than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	Director	217 S. Dallas Court 21231 USA
death wit	Funera	11. Marital Status unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 1 Never Married 2 Married 12 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
s after de rral", or niner m	þ	3 Wildowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify black
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sho and 7 is	٢	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0.C.M.E. 111 Penn Street Baltimore, MD 21201
ore, ME es I and 2 s' of Health an If item 27 her traums		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
		4 Donation 5 X Other Specify: in state
Baltir permit. B Departme Importar		21 Shinature of Euneral Struce Licensee Ronald S. Wade Virector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
Physician	-	23a Part I. Enter the disease, or complications triat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a Narcotic intoxication and open of the condition resulting in death) Due to (or as a consequence of):
		Sequentially list conditions, b
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated c
scuted and transit		events resulting in death) Last Due to (or as a consequence of): d.
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8760, ifficate be er ng physician		IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Fectoric pregnancy Month Day Year
Box 687 e death certific the attending p	Physician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
that the de red by the detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death?
s, P.O. ires that t signed by	d by	1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after deanth an Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed?
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Vital hysician: this certifi	o Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other
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isior Attend ar death rector: by the	icatio	Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F × F 8	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		O.C.M.E. December 11, 2006
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
S Regis	tate	31. Date filed (Month, Day, Year) DEC 2, 7, 2006
Regis	للخلام	DLV (1 / HH) Property File Contracts B

		•	For State Registrar	otate of Maryland	-	rtificate of	Death	Reg	. No. 2 () () (5 41193	
В	Physici	an ·	1. Decedent's Name (First, Middle, I Lori Sue C				1	2. Date of Death Month	Day Year	3. Time of Death	
	/Medic Examir		4a. Facility Name (If not institution, g			4b. City, Town, o	r Location of Death	12	23 2006 6:47 A M		
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\$1.	Funeral Director		216-88-4436	. Sex 1 ☐ M 2X F 7. Age (In yrs. It 4.4		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	3. Date of Birth (Month, Day, Y 10/2/19	ear) C	thplace (State or Foreign ountry) ryland	
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
	ne Mary Ba-f sho stiffied a	ctor	MD Balti	more P	arkvi	lle				1 ☐ Yes XXNo	
	ath with the 23a or 20 ust be no	Funeral Director	8017 Oakleig	h Rd.			234		. Citizen of What C	ountry?	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ğ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 🗶 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2⁄ॣ No	lispanic Örigin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whi	te, etc.	
	in 72 ho n "natu ledical	Completed	15. Decedent's (Specify only highest)	grade completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of working d)	7	b. Kind of Business	/Industry	
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Maryland	12 sho h and 7 Is ma trauma		19a. Informant's Name/Relationship Dale E. Axels		1		and Number or Rural				
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Baltimore,	t. Partmer		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				Decei	mber 006 P	arkvill	e, MD	
Bal	permi Depa Impo any Ir		21. Signature of Funeral Service Lie	censee /	Ev An	2. Name and Addre Tans Fun d Crema	eral Char tion Ser	oel p Vices	800 Har Parkvill	ford Rd. e, MD	
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Records,	To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	Completed						24a. Was an autopsy performe 1□ Yes 2 □	d2- death?	utopsy findings available completion of cause of	
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or V	Physician: this certificaral director, p	To	1 ☐ Yes 2 Z No			nt 3□ DOA Oth	4 LI Nursing Hom	e 5 Residenc	ce 6 Other (Spe	ecity) Hospic	
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	with To t	Σ	29b. Signature and title of certifier MAAA	my Mily	no	D 2		29d	December	th, Day, Year)	
	6		30. Name and address of person wi	no completed cause of leath (Item	23a) (Type,	Print) Al-Cha	les St.	Bald	Md Zc	203	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Contes					
61	B 41 L 47 D 4/6	004		4	d)	1					

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awrence Conw		1- For State Registrar	Maryland / Depa	rtificate of D		nd Mental I		Reg. No.	200	5 4 1 1 9 1
Physici Medical Exami		Decedent's Name (First, Middle, Last) Lawrence E. Conwa	У				2. Date of Month Decem	Death Day ber 24, 20	Year 006	3. Time of Death 0010 hrs
		4a. Facility Name (if not institution, give st Philadelphia Road and Ches			City, Town, o	r Location of Dea	th		County of Death	
Funeral Director			7. Age (In yrs. Is 74		f Under 1 Yea Months Day			f Birth(MM/D y 1,19	D/YYYY) 9. Bird Foreig Cor	hplace (State or n untry) Md.
any	ł	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location						10d. Inside City Limits
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leath witl r items 2	Funeral	11. Marital Status 1 Never Married 2 X Married	2. Was Decedent Ever in U. Armed Forces? Yes 2 X No			ispanic Origin? (in, M exican, Puer			 Race - Ameri White, etc. 	can Indian, Black,
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2121! uld be fil Mental F marked	To Be	Edward Conway 19a Informant's Name/Relationship (Type	Print)	19b. Mailing Ad	Idress (Stre	or Town, State	Zin Code)			
MD 7 rd 2 shou thth and 1 m 27 is r		Pauline Conway	wife	906 Fo	rwood	Ct. Dun	dalk Mo	a. 212	22	
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked of injury or other traumatic event. It		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specify	Removal from State	Place of Disposition crematory or other cdens of	_{place)} Faith	cem. De	ec. 30 2006	R	ocation - City or	
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Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: Or	To the best of my knowled the basis of examination a d manner stated.							
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V		30. Name and address of person who com Margarita Korell MD. Assis	pleted cause of death (Item stant Medical Examin		n Street, E	Baltimore, ME	21201			
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	and the second				-		
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)	Examir		4a. Facility Name (If not institution, give)				Location of	of Death				y of Death		
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	or 28	Director	10e. Street and Number				10f. Zi	p Code				10g. Cit	lizen of	What Cou	ntry?	
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36	or It		1 Never Married 2 Married	1 ☐ Yes 2 ☑ If Yes, Give			1 ☐ Yes		Specify:		7 110211, 010.7		Speci		etc.	
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	Hyg the int.		17. Father's Name (First, Middle, Last)			Home	marce		18. Mothe	er's Name	e (First, Midd					
an	should be id Mental marked o matic eve	To Be	James Gobbett						Alic							
Maryland	& B E E	-	19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailin	g Addres	s (Street a			al Route Num	ber, City o	or Town	, State, Zip	Code)	
	alth a		Nancy Prentiss /	Daughter		38770	Gra	nt Av	7e.,	Se1b	yville	• DE	199	75		
			20a. Method of Disposition			Place of Dispo	sition (Na	me of		Dec.				- City or To	wn, State	
Ē	Pages nent of int: If It		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Denation 5 ☐ Other (Specify,			ownsvil					2006	Crow	msv	ille.	Marv1	and
Baltimore,	permit. Page Department of Important: If eny Injury or once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 2											21061			
			23a. Part1. Exter the disease, or comp shock, or heart failure. List only	lications that cause	d the dear										Approximate Interval Bety	veen
# 1	Pnysician	e i	Immediate Cause (Final disease or condition	a MULTLA	LE T	PLEURA	LEF	Fusia	NS					6	Onset and D	Death
1	/Medical Examiner		resulting in death)	Due to (or as					,- ,						olet (D	,
	Lxaiiiiiei		Sequentially list conditions,	b												
	2 A 8	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	d consec	querice of).										
	and and	xan	that initiated events resulting in death) Last	c Due to (or as	a consec	uence of):										
8760,	the death certificate be executed y the attending physician and content of the deformance as the burial-transit	<u>ea</u>		`		, .										
687	ficate physics the	edical		d										ret.		
Вох	eath certific attending p	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy								23d. Date of delivery				
	death e atte d for	cla	in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 4□Pregnant a			Ectopic p Other (s _i							onth	,	'ear
P.0	at the de by the tached	Physician/Me	9 Unknown	9☐ Unknown												
S, F	The law requires that ate has been signed b age 2 should be deta	by P	Part II. Other significant conditions co						n in Part I.		23e. Did	I tobacco i	use con	tribute to th	e cause of de	eath?
ord	w require been si should b	ed	CHRONIC OBSTRUCT	IVE PULM	IONA	RY DIS	EASE				1 🗆	Yes 2	□ No	3 Prob	ably 4 □U	Inknown
ec	lawr as be	ble									24a. Wa	s an opsy	24b.	Were auto	psy findings a notetion of ca	ivailable
<u>=</u>		Completed									per 1 ☐ Yes	formed?		death? 1 ☐ Yes		
/ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	,				-	26. Place	of Death	Check only	one)				
of \	Physi this c al dir	ဥ	TI THE ZEINO			ER/Outpatien			4 🗀 190		me 5□Res				1)	
n C	ling After unei	o	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry ıy Yea <i>r)</i>	28b. Time of Injury		28c. Injury Work			28d. Describe	how injur	y occui	rred		
isi	Attending r death.	cat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of In	iune - At h	ome form str	M .		/es 2 □ I		28L Location	(Street as		has as Own	/ Courte Mount	
=		Certification;	4 Homicide determined	building, etc. (Specify) City or Town							own, State					
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	ledical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	sician: To the best ner: On the basis of and manner st	of examina	owledge, death ition and/or inv	estigation	ı, in my op	inion, dea	d place, th occurr	and due to the	e cause(s) e, date and	and m d place,	anner as st and due to	ated. the cause(s)	
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	-	1 Mer	WE ASSIG		c. License				29d. Da	te signe	d (Month,	Day, Year)	
	5				(Ho:	ASE OFFICE	(2)	?E5 (000			DECE	MRE	R 26	, 2006	2
	H		30. Name and address of person who c	1	death (Iter	1 23a) (Type,		STRE	ET	BA	LTIMOR	EM	ARV	LAND	2122	5-
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	_					41	,	, , ,				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 20b per fh 9863 I-II-07 vt
State of Maryland? Department of Health and Mental Hygiene

			Certificate of Death	Reg. Ng2 006 41196				
	Physician	Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month Month Day 2. Dete of Deeth 3. Time of Death				
d.	/Medical	Dorothy Chow		December 26, 2006 6:00 am				
	Examiner	4e Fecility Name (If not institution, give street and number) 9 Intervale Court	4b. City, Town, or Lo Towson	Baltímore				
s)	Funeral Director	579-46-0099 1DM 2XDF 83	rrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	B. Date of Birth Dec. 1, Yearl 1922 9. Birthplace (State or Foreign Confine na				
	pu k	Usual Residence of Decedent 10a, Stete 10b, County 10c,	City, Town or Location	10d. Inside City Limits				
	the Maryle 28e-f sho notified in		Towson	1 □ Yes 2 💆 No				
	after death with the Mai w thems 23e or 28e-1 sin Infer must be notified Funeral Director	9 Intervale Court	10f. Zip Code 21286	10g. Citizen of Whet Country? USA				
0200	by Br.	3 Widowed 4 □ Divorced	1 ☐ Yes 2 X No Specify:	Specify: White				
Maryland 21215-0020	ied within 72 hours bygiene. her than *natural' nt, the Madical Ex Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired) School Teacher	ing 16b. Kind of Business/Industry Education				
2	e filed v al Hygie other t vent, th	17. Father's Neme (First, Middle, Last)						
yland	2 should be fi end Mental H is marked ott sumatic ever To Be	Wan-nin Wai		me (First, Middle, Maiden Surname) Hou				
, Mar	and 2 shi halth end 127 is m er trsum	19a. Informant's Name/Relationship (Type, Print) Mr. David Forrer/ Attorney	ural Route Number, City or Town, State, Zip Code) Baltimore, Md. 21202					
Baltimore,	permit. Peges 1 and 2 should be filed Depertment of Health end Mental Hyg Important: If Item 27 is marked othe any injury or other traumatic event, DICE. To Be C	20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify)	1-9te 07 20c. Location - City or Town, State Baltimore, Md.					
Balt	permit. Depertium of the permit of the permi	21. Signature of Funeral Service Licensee	ral Home, Inc. wson, Md. 21204					
		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	eath. Do not enter the mode of dying, such as cardiac	or respiratory arrest, Approximate Interval Between				
1	Physician /Medical Examiner		rkensons Dissie	Opent and Death				
	je le le le le le le le le le le le le le		o (or as a consequence of):					
68760, <	rificete be executed no physician end est the bunel-transit	if erry, leading to immediate cause. Enter Underlying Cause (Disease or injury c	o (or as a consequence of): (or as a consequence of):					
Box 6	death certificate be e attending physicia of for use as the bur sician/Medical	d						
	e dea the at hed fo	Part II. Other significant conditions contributing to death but not r		23b. Did tobacco use contributa to the cause of death?				
s, P.O	es thet the death ce igned by the attendi be deteched for use by Physician/I		118802	1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣ Unknown				
of Vital Records,	requir	Possesset strates	24a. Was an eutopsy performed? 24b. Were autopsy findings aveilable prior to completion of cause of deeth?					
E R	sician: The law scrifficate has the director, page 2 so the Compile of the Compile of the compil		1 ☐ Yes 2 ☐ No					
Vita	clan: sertific ector.	25. Was case referred to medical examiner?	26. Place of Death					
of	Physician: this certific ral director,			The Sesidence 6 Other (Specify)				
n	ling F After funer ion	Naturel 5 Pending (Month, Day Year)	28b. Time of 28c. injury at 28b. Time of 10 10 10 10 10 10 10 1	28d. Describe how injury occurred				
Division	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At building, etc. (Spe	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	hours a hours a ineral C y filled	29a. Certifier Dertifying Physician: To the best of my k	nowledge, death occurred at the time, date and place, a	and due to the cause(s) and manner as steted.				
	To the Hospital within 24 hours. To the Funeral completely filled	(Check only one) 2 Madical Examiner: On the basis of examinand menner stated. 29b. Signature and title of certifier.	ination and/or investigation, in my opinion, death occurre					
	5.≱ C o	Styliatura and the destination		29d. Date signed (Month, Dey, Year)				
	6	30. Name and address of person who completed cause of death (ft	rem 23a) (Type Print)	12.26.66. Med 2,093				
	State Registrar	31. Date filed (Month, Day, Year) 32. Redistrar's Sig	nature Aparks					

			100	artment of Health and Menta <i>rtificate of Death</i>	Il Hygiene Reg. No. 006	41197		
	Physici	an	Decedent's Name (First, Middle, Last) Factorial	O la la Mo		3. Time of Death		
1	/Medic	-	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea			
	Examin	er	The Johns Hopkins Hospital	Bultimore City	10.002.10, 0.200	•		
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date	e of Birth 9. Bir	9. Birthplace (State or Foreign		
и	Director		219.70.9545 15M 20F 42 Yrs.	Months Days Hours Min. (Mo	nth, Day, Year) C -26-1964 Mai	64 Maryland		
	ם ,		Usual Residence of Decedent			1		
	aryla ehov	_	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 🗙 No		
	he M 8a-f	ecto	MD Daltimore YIK	esville	1	/-		
	with t	ă	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?		
	death with the Maryland me 23a or 28a-f ehow roust be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was December of Hispania Origin? (Specify Va	s or No- 14. Race - Am	encan Indian		
	her d	Ē	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, o	etc.) Black, Whi			
99	urs al	ρ	3 ☐ Widowed 4 X Divorced If Yes, Give / Year or Dates:	1 ☐ Yes 2 🗖 No Specify:	Specify: P	lant		
21215-0036	72 hours after naturel', or ite	Completed	15. Decedent's Education 16a. Dece	ident's Usual Occupation	16b. Kind of Business	Industry		
21	within 7 ene. then r	ple	(Specify only highest grade completed) (Give life. Elementary/Secondary (0·12) College (1-4or 5+)	b kind of work done during most of working DO NOT use retired)	4.1			
7	filed within Hygiene. other then	Cou	12th Grade tmerc		Howard C	ounty		
P	d off	Be	17. Father's Name (First, Middle, Last)		Middle, Maiden Sumame)	/		
₹ Za	Men Men Marke	ို	Adell Clark	ing Address (Street and Number or Rural Route	le Howie			
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then 'naturel', or item 23a or 28a-f show or other traumatic event, the Medical Examina must be notified at		A A	17/15				
	1 end Healt em 2 ther		20a. Method of Disposition 20b. Place of Disposition	Hanually Princials	20c. Location - City or	Town State		
5	Pages nent of nt: If it iry or o		1 Burial 2 Cremation 3 Removal from State	matory or other place)				
Baltimore,			4 Donation 5 Other (Specify) Woodle. 21. Signature of Funeral Service Licensee 2:	2. Name and Address of Facility Vocus on	C. Giren Juneau	Becorde		
ã	permit. Departr Importu any inji		Naugha C. Sheeman		allstan mD			
			23a. Part1. Enter the disease, or complications that ceused the death. Do not en			Approximate Interval Between		
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition STEPTOCICE S		Onset and Death			
т	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Steptocical S Due to (or as a consequence of):	Epite Source		Sawys		
	Examiner		Congestive Heart	Failure		1 wear		
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying					
14	and and trans	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):					
8760,	death certificate be executed e ettending phystcien and rd for use as the buriat-transit		335 (5) (5) 23 2 33(13)940(105 37).					
687	ficate physics to the	edical	d.					
Вох	eath certific ettending pl for use as t	N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	livery		
œ.	death e ette nd for	Physician/M	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	Month	Day Year		
P.O.	thet the de ned by the e detached t	hys	9 Unknown 9 Unknown					
	iaw requires thet the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I. 23	e. Did tobacco use contribute t			
9	requi	ted			1 Yes 2 XNo 3 P	robabiy 4 Dunknown		
Sec.	has b	Completed		244	autopsy prior to	utopsy findings available completion of cause of		
a	The ele			1	performed? death? Yes 2⊠ No 1 ☐ Yes	s 2 No		
¥	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check				
ō	r this	7: 70	1 ☐ Yes 2 5 No 1 1 ☐ Inpatient 2 ☐ ER/Outpatient 2. In anner of Death 28a. Date of Injury 28b. Time of Death	TIL 3 DOX 4 Nursing nome 5	☐ Residence 6 ☐ Other (Spe scribe how injury occurred	ecify)		
on	Attending it death. ector: After by the fune	ş	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28b. Time of Month, Day Year) Injury 28b. Time of Month, Day Year)	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No 28d. De	(A)			
Division of Vital Records,	Attendiar death.	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		ation (Street and Number or R	ural Route Number,		
ے	rs efter el Dire ed in by	or rown, State)						
)	To the Hospital or Attending Physician: within 24 hours eller death, within 12 the Fundrel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Crieck Only Locatifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, and due ivestigation, in my opinion, death occurred at the	to the cause(s) and manner as	s stated.		
	the the mplet	Med	one) and manner stated. 29b. Signature and title of certifier	29c, License number	· · · · · · · · · · · · · · · · · · ·			
	N N N		Medical Docto		December 26			
•	į		30. Name and address of person who completed cause of death (Item 23a) (Tune	Print)	- 100 W-1 - 1 - 1 - 1 - 1	1		
	V		Jacolyn Kim . The Johns Hyking Hosy	rital, 600 North Wolfe St	rect, Baltimore, N	langland 21287		
	Sta	te	31. Date filed (Month, Day, Year) 32. Hagistrar's Signature					
	Registr	ar	DEC 2 7 2006 Brown &	rould				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 21, 2006 12:00 P M IRWIN COHEN ROBERT 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours Days 09/04/1924 218-16-2341 MD 82 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 SLADE AVENUE #502 21208 U.S.A. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give X Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) LAWYER LAW 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) TANKOOS COHEN **ELEANOR** MANUEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 SLADE AVENUE #502 - BALTIMORE, MD 21208 BETTY W. COHEN / WIFE 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CONG. 12/22/2006 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Tocal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arkinson's Pisease Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate sauss. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example.

Examiner Physician/Medical

attending physician and for use as the burial-trar ģ has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Completed P Certification:

q pa	Dementia			_		1 🗆	Yes 2□] No 3 ☐ Probably 4	Unknown			
Completed								24b. Were autopsy findir prior to completion death? 1 □ Yes 2 □ No	igs available of cause of			
Be (25. Was case referred to medical	26. Place of Death (Check only one)										
To B	examiner? 1 ☐ Yes 2 ☐ ₩6	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3[DOA Other: 4	Nursing H	ome 5□Res	idence 6	Other (Specify)				
Certification: 7	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe	28d. Describe how injury occurred					
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify		ctory, office		28f. Location (City or To	(Street and wn, State)	Number or Rural Route I	vumber,			
Medical C							nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)					
×	29h Signature and title of certifier		29c. License nun	nber		29d Date signed (Month Day Year)						

29c. License number

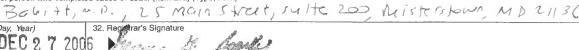
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29d. Date signed (Month, Day, Year)

December 21, 2006

State Registrar 31. Date filed (Month, Day, Year) DEC 2

29b. Signature and title of certifier



Kaun L. Ballit, M.D.

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)-2. Date of Death Month 7:00 AM **Physician** Day 39,200 WISIPPO Rander /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caton Manor Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) unk 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 193-16-5350 Director 82 Sept 18, 1924 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1√2 Yes 2 □ No Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 116 Birkhead Street 21223 USA ural", or items 2 I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2 🔀 No Specify white Completed by 3 Widowed 4 Divorced unk other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unki 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Mary Brashears/friend 114 Birkhead Street Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any Injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☑Other(Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 3a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumone /Medical Due to (or as a consequence of): Examiner Stuffen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury consequence of): Due to (or a Examiner Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No Probably 4 ☐Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page **OX** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier, 29d. Date signed (Month, Day, Year) 1)25044

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Hammu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

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32. Registrar's Signature

06-09410

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

iarriet Davis		State of Maryland / Department of Health and Mental Hyg 1- For State Certificate of Death Registrar	rene Reg No. 2	006 61201
Physicia Medical Exami			Date of Death Month Day December 10, 2006	3. Time of Death 7'ear 1101 hrs
E from		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. Count	ty of Death
Funeral		Franklin Square Hospital Social Security Number 1 Year 1 Under 24Hrs. 8		ore County YY) 9. Birthplace (State ounk
Director		1 M 2XF 48 Yrs. Months Days Hours Min.	pr 15, 1958	Foreign Country)
any	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
staryland 28a-f show 1 at once.	Ď	MD Baltimore 10e Street and Number 10f Zip Code	140 000 40	1 X Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural" or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number 6002 Moravia Park Drive 10f. Zip Code 21206	10g. Citizen of	USA
ath with items 23 ist be no	Funeral	11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ric		ice - American Indian, Black, nite, etc.
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21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'e event, the Medical	Be	17. Father's Name (First, Middle, Last) unk 18. Mother's Name (Fi	ist, Middle, Malderi Surriar	ne) unk
e, MD 2121 I and 2 should be it Health and Mental item 27 is marker	유	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural O.C.M.E. 1111 Penn Street Baltin		
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Baltimore, permit Pages I ar Department of Hee Important: If iter		4 Donation 5 X Other Specify: in State 24 Signature of Funer Service License 22. Name and Address of Facility		
Ba perm Depa Impo injur		onald S Vd Directo State Anatomy Board Baltimore, MD 21201		
Physician /Medical	^	Aa, Part I. Enter the fise se, of complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure, List only one cause on each line.	spiratory arrest, shock, or h	neart Approximate Interval Between Onset and Death
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	ner	Sequentially list conditions, if any, leading to immediate the control of the labeling Course. Extra Marketing Course.	ilsease	
i i	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):		
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760, icate be physicate the puri		#23a-h, PTT, 27, perMF, g863, 1/2/07 TT #3a-h, PTT, 27, perMF, g863, 1/2/07 TT 23c. If yes, outcome of pregnancy 23d. Was decedent pregnant in the	23d. Date	
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p.O. Box 687 that the death certific ned by the attending p detached for use as th		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did tobacco use cor	ntribute to the cause of death?
S, P.(uires than n signed d be deti	ed by	End stage renal disease; diabetes mellitus	1 Yes 2 ✔ No	
cords, law requir has been s	Completed	['	autopsy performed?	. Were autopsy findings available prior to completion of cause of death?
Vital Rec ysician: The his certificate director, page	Be Cor	25 Was case referred to medical 26 Place of Death (Check only	one)	1 Yes 2 No
	ပ	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other4 Nursing H 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work?	ome 5 Residence 6	
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Di Hospital 24 hours a Funeral I ttely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due (check only).		
To the Howithin 24 h	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated. 29b. Signature and title of certifier 29c License number		due to the cause(s)
		Josh R Yeal Ma O.C.M.E.		er 11, 2006
		30. Name and address of pers in the completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201	
		31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Regist	rar	DEC 2 7 2098 Jan 18 Jan 18		

DHMH 17 Rev 1/2001 OCME 2006

ion or Vital Becords, P.O. Box 68760. WILLIAM DEVLIN

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		For	ype or Print State of Ma	ryland / Dep	partment of H	lealth and	-	_	le.
		State Registrar		C	ertificate of	Death		Reg. No. 2	16 41201
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		Stella Maris	7 400	/In um to at hirthda	Timoniu		8. Date of Birt		nore County 9. Birthplace (State or Foreign
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aryland show	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 2 No
the M 28a-f notifie	ect	Maryland Baltimo 10e. Street and Number	re	Parkvil	10f. Zip Code			10g. Citizen of W	hat Country?
3a or	ä	3031 Balder Avenu	е		21234			United S	States
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:		3. Was Decedent of I If Yes, specify Cub 1 Yes 2 No	Hispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No rto Rican, etc.)	- 14. Race Black Specify:	- American Indian, , White, etc. Wnite
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od 2 shoulth and N		19a. Informant's Name/Relationship (7) Mrs. Mary Jane De		i	ailing Address <i>(Stree</i> 1 Balder <i>I</i>			-	
s 1 all of Hear item		20a. Method of Disposition	2 15 01-4-	cemetery, c	sposition (Name of rematory or other pla	(ce) 12.	Date		City or Town, State
Pages nent of l ant; If its	1	1 ☐ Burial 2 ② Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		Evans F	uneral Cha	apel / "	21-06	Forest I	Hill, Maryland
permit. Departr Importa any inju		21. Signature of Funeral Service Licens	Lezw	_	22. Name and Addr Evans Fune 8800 Harfo	eral and	Crematic Parkvill	on Servic le, Mary	ces Land 21234
		23a. Part1. Enter the disease comp shock, or heart failure. List only of	lications that caused ne cause on each line	the death. Do not	enter the mode of dy	ing, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. <u>COLON CA</u> Due to (or as a	NCER consequence of):					Origer and Death
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VICAL INECOLUS, F.C. BOX 00/00, vicines. The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	cy		23d. Date Mor	e of delivery ath Day Year
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Or VICA Physician: rthis certifica ral director,	O B	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpa	tient 3 DOA	hor:			er (Specify) HOSPICE
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Hospita 24 hours Funera etely fille	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination and/o	eath occurred at the r investigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s) and ma , date and place, a	nner as stated. and due to the cause(s)
To the within To the Comp	Me	29b. Signature and title of certifier			29c. Licer	ise number		_	(Month, Day, Year)
	1)				4372	5	12/	126/06
FH	1	30. Name and address of person who						000	
	tate	DR. TARIO MAHMOO 31. Date filed (Month, Day, Year)		ULANEY VA ar's Signature	LLEY RD.	TIMONIU	M, MD 21	093	
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DHMH 17 Rev 1/	2001		4		2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Vear 23 2006 P.C. Ruth Williams Davman 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAINT Agnes Healthcare BACTIMONE
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M & T 11/24/1919 87 Pennsylvania 164-18-2214 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 TNo Maryland | Howard Elkridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21075 USA 6391 Rowanberry Drive, Apt 427 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin Boaz Price Grace R. Keyser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5851 Diggers Lane, Elkridge, MD 21075 Beverly Dayman- daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 12/29/2006 22. Name and Address of Facility
Gary L. Kaufman FuneralHome at MMP, 21. Signature of Funeral Service Licensee My 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) care brownseulas 15 min Atherosterons Due to (or as a consequence of): Sequentially list conditions, If any factory to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of : Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Lngeshise Heart 1 Yes 3 ☐ Probably 4 ☐ Unknown Hypertensim 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2□No 1□ Yes 2 1Kg 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 NO 1 ☐ Inpatient 2 ☐ 54/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Division or Vital Records, P.O. Box 68760

burial-trar attending physician has certificate Director: filled in by the To the Funeral

Physician

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permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau
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Physician

/Medical

the Maryland

filed within 72 hours after death with

Maryland 21215-0036

Baltimore,

within 24 hours Registrar

State

31. Date filed (Month, Day, Year)

29a. Certifier

MD

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

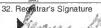
29b. Signature and title of certifier

and manner stated

South Caton Avenue

December 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Checkley MD Meghan



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ikki Day Month Year tuos 2006 12 Zo 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death University of Maryland Shock Trauma Center Baltimore Ba (fimore If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ☐ M 2 🖾 F 56 220-48-8950 18, 1950 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 8 Nunnery Lane Apt. 2 21228 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Course Administrator Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William L. Enos, Jr. Julia Mentis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Mentis 1811 Army Navy Drive; Arlington, VA 22202 Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) thodox Cem. 12-30-2006 Windsor Mill, Maryland
22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke
Funeral Home of Catonsville, Inc. Greek Orthodox Cem. 21. Signature of Fundal Service Licenses 1101290 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory agrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TEMPERAL MARCHE BY WELL multi & Taum

Due to (or s a consequence of): trauma over who limited Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗖 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? traumet c hrain 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

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Examine

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and s the burial-trans Box 68760, death certificate be as attending p ed by the a detached f P.0. signed t Records, been

page 2 s certificate funeral director After this

> 5 State

Medical

Physician/Medical ģ Completed Be P To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Certification:

27. Manner of Death

1 Natural

2/Accident

3 ☐ Suicide

29a, Certifier

EDWARD LI

4 Homicide

(Check only one)

29b. Signature and title of certifier

DEC 2

5 Pending investigation

6 Could not be determined

2006

Division or Vital

P13154 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDWITED LT, 22 S. Greeve St. Beltime ru. 37 Registrar's Signature 7

28a. Date of Injury (Month, Day Year)

12-17-2006

and manner stated.

Registrar

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

1739 PM

28c. Injury at Work?

Street

Corner of Frederick and Naumen

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The physician of the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and meaning the physician of the pages of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 🕱 No

28d. Describe how injury occurred

Truck

29d. Date signed (Month, Day, Year)

12-20-2006

Location (Street and Number or Rural Route Number, City or Town, State)

Struck

			1 - For State Registrar		State of	Marylan		artment of I			_	giene	IIII	41204		
	Physici		Decedent's Name (First, Mid GLADYS	1/e, Last)			ERTW	INE		Ī	2. Date of De Month ECEMBE	_	, 2006	3. Time of Death 4:30 A M		
	/Medic Examin		4a. Facility Name (If not institut	on, give s	treet and numi	ber) 4b. City, Town, or Location of Death						4c. County of Death				
			FOREST HILL H						EST H					FORD		
漫	Funeral Director		5. Social Security Number 170–26–9549	6. Sex	M 2 ⊠ F 7	. Age (In yrs. 90	last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bird (Month, Da Jul. 2	h y, Year) L, 1	916 N	lirthplace (State or Foreign Country) EW York		
	land		Usual Residence of Decedent 10a. State 10b. Coun	ty		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits				
	Mary First	tor	Maryland Har	ford		P	ylesvi	11e					1 □ Yes 2 X No			
	or 28g	Director	10e. Street and Number					10f. Zip Code				10g. Citi	zen of What	Country?		
	23a c		132 Wheeler	Schoo	ol Rd.			2113	2				USA			
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'ms Micdical Exactil at trainst be notified at ance.	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma		2. Was Deced Armed Ford 1 Tes 2 If Yes, Give	es? No		Was Decedent of I If Yes, specify Cub	ian, Mexicar	n, Puerto I	icify Yes or No Rican, etc.)		14. Race - American Indian, Black, White, etc.			
21215-0036	ural',	d by	3√ Widowed 4 □ Divorce		Year or Dat	tes:		1 ☐ Yes 🏋 No Specify:					Specify: White			
<u>5</u>	natu	Completed	15. Deced (Specify only high				(Give	dent's Usual Occup kind of work done DO NOT use retire	durina mos	t of worki	orking 16b. Kind of Busines			ss/Industry		
12	withir ene. then	шc	Elementary/Secondary (0-12		College (1-	4or 5+)		maker				Ox	n Home			
	Hygi other	BeC	17. Father's Name (First, Middl	, Last)			1101110		18. Mothe	er's Name	(First, Middle,					
lar	uld be Wenta Irked Itic ev	To B	William Augu	st So	chrader				Clar	ra Ar	Ardel Marshall					
Tr. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) William August Schrader Clara Ardel Marshall 19a. Informant's Name/Relationship (Type, Print) Mary E. Norris / Daughter 19a. Mailing Address (Street and Number or Rural Route Number, City or Town, State Mary E. Norris / Daughter 19a. Mailing Address (Street and Number of Rural Route Number, City or Town, State Mary E. Norris / Daughter 19a. Mary E. Norris / Daughter 19a. Mailing Address (Street and Number of Rural Route Number, City or Town, State Mary E. Norris / Daughter 19a. Mary E. Norris / Daughter 19a. Mailing Address (Street and Number of Rural Route Number, City or Town, State Mary E. Norris / Daughter											Town, State					
	1 and 1ealth em 27			s_/_I	Daughte	r			t., W		ord, M			160 or Town, State		
20a. Method of Disposition 1																
텵	artme ortani injury		21. Sign flur of Funeral Arvis Legal 22. Name and Address of Facility McComas Funeral Home, P. A.											, Maryrand		
Ba	Depariment of the policy of th		Hudk	1/U	100	V-	_ M	cComas Fi 50 West 1	unera. Broadv	l Hom vav,	e, P. A Bel Aij	λ. c. Μa	arvlan	d 21014		
			23a Part1. Enter the disease, shock, or heart failure. L	or complic	cations that ca	used the deat								Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death) a. nespective feedback Due to (or as a consequence of): b. probable ashirular													
42	Medical Examiner		resulting in death)		Due to (o	r as a consec	juence o):									
	Examine	7.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ь	Dua to to	Lulel	each	interes								
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	⊀∵.	(-		a an soque tree org.									
o,	ate be executed thysicien and the burial-transit		resulting in death) Last													
68760,	ate be physicie the bu	Icai		d												
	death certifica e attending ph ed for use as th	Physician/Med	IF FEMALE:		2- 14											
Box	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	2.		ome of pregna th 2 □ Feta int at time of d	al death 3	∃Ectopic pregnanc	у			2	3d. Date of one of the Month	delivery Day Year		
P.O.	The de y the iched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9☐ Unknov		164(1) 5(
Ś	Physician: The law requires that the death certific this certificate has been signed by the attending p ral director, page 2 should be detached for use as	by	Part II. Other significant cond			2	sulting in the u	nderlying cause gr	ven in Part I	l.		obacco u /es 2[to the cause of death? Probably 4 SUnknown		
oro	w require been sig	eted	chronic r						•							
3ec	Competition Limits Territ furthers Competition Compet										24a. Was autor perfo	sy	24b. Were prior t death	autopsy findings available o completion of cause of		
performed (1 yes 2 D) 25. Was case referred to medical 26. Place of Death (Check only one)									2 No	1 □ Y	es 2No					
5	ysicia s cert directe	ToB	examiner?		ospital:	patient 2	ER/Outpatie	nt 3 DOA Ot			n <i>(Check</i> only o		S∏Other (Si	pecify)		
10	ng Phy ter thi		27. Manner of Death	dia a	28a. Date of (Month		28b. Time o				28d. Describe			,		
Sio	endin Bath. or: Af the fur	catic	2 Accident inve	stigation		,,,	,,		Yes 2							
Division of Vital Record	or Att	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined	28e. Place of building	of Injury - At h g, etc. (Special	ome, larm, st fy)	reet, lactory, office		1		(Street and Number or Rural Route Number, own, State)				
_	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 15 Certification (Check only 27 Medic	ing Phys	sician: To the bases	best of my kno	owledge, deat	h occurred at the t	ime, date ar	nd place, a	and due to the	cause(s)	and manner	as stated. lue to the cause(s)		
	ithin 24 o the F omplete	Med	one) 29b. Signature and title of certi		and manne				se number					onth, Day, Year)		
	- 5 - 8		Dans 3	2				03	225	c		Des	embe	120,2000		
	, ~		30. Name and address of person	n who co	mpleted cause	of death (Iter	т 23а) (Туре,		/					, = - 5 (
	le		DAVID DUNN -	61	5 W. MA	CPHAIL	ROAD	- BEL	AIR, 1	MD.	21014					
	Sta Regist		31. Date filed (Month, Day, Ye	272	32. Re	gistrar's Signa	ature A	parte								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 8:15 AM Dec Jane ELIZABETH 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 205 ST MARKWAY APT 577 WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) RN7 1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 162 12 8699 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, in Medical Examiner must be notified at 1 Yes 2 □ No mn CARROLL Funeral Director WESTMINSTER 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 205 ST MARK WAY 2115 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene.

Is marked other than HUMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental MARTHA HURLEY Woomer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ESP WESTMINSTER MO 2115 & KONALO It. HUSBAND 205 STMARK WAY APT 577 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Sykesville, mo LAKE UIEW Mem PK 12/27/2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility JN ZUMB TWO GODE SYKOVILLERD ELDE

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the prode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility JN ZUINB WW IFH & MUNCO. 6028 SYKOVILLERO ELDRISBURG-MO21784 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 plonths? 1 ☐ Yes 2 No 9 ☐ Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To Manner of Death 28d. Describe how injury occurred filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No ; after death. investigation Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

31. Date filed (Month, Day, Year) DEC 2 7

			For State Registrar	State of Ma	arylan	-		nt of He te of E			ental Hy	gien	U U (5	412	06
	- S 19		1. Decedent's Name (First, Middle,	Last)						-	2. Date of De	aath			3. Time of	Death
	Physici		TOHN	DOUGLAS	5	FORR	FST	•			Month	170	D Zoc	ear	7.350	4 M
	/Medic Examin	_	4a. Facility Name (If not institution,					Town, or	Location	of Death			. County of		6.4	
1000	LAGITIII	C 1	Brightwood Nurs		Cen	ter		imoni				Baltimore				
	Funeral	9				last birthday)		r 1 Year	II Under		8. Date of Bi	rth			place (State o	r Foreign
. 40	Director		219-05-4847	1 ∑ M 2□F	86	Yrs.	Months	Days	Hours	Min.	(Month, Day 2)		1			
	7		Usual Residence of Decedent							1	may Z		720	Tary	land	
	nylan how Lat	,	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside Cit	•
	Ma a-1 s	tol	MD		Ba1	Ltimore	2								1X Yes	2 🗌 No
	17 th	Director	10e. Street and Number				10f. Zi	Code				10g. C	itizen of Wh	at Cour	ntry?	
	23a d	al	6404 Sharon Roa	d				21	L239				TI	7 A		
	within 72 hours after death with the Maryland ene. than "netural", or Itams 23e or 28e-f show the Madical Examinat must be notified at	by Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	.S. 13.	Was Dece			igin? (Spec	ofy Yes or No	0-	14. Race	Amend	an Indian,	
9	or Itu	F	1 ☐ Never Married 2 X Marrie		No		_	/as Decedent ot Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2∑ No Specify:								
8	ours		3 Widowed 4 Divorced	Year or Dates:	41-	47	1 1 43	ZA NO	эрвспу.				Specify:	whi	te	
ည	72 h natu	Completed	15. Decedent's (Specify only highest			16a. Dece	kind of wo	ork done di	u <i>rina m</i> os	st of workin	unk 16b. Kind of Busine			ness/Ind	dustry	unk
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7	ygier ygier t, t	ပိ	12	4										-		
밑	tal H d oth	Be	17. Father's Name (First, Middle, L.	·					18. Moth		(First, Middle	, Maide	n Sumame)			
<u>×</u>	should be and Mental	၉	Paul Vernon For	rest						Lena	Ware					
Maryland 21215-0036	2 sh and and isum		19a. Informant's Name/Relationshi								Route Numb			ate, Zip	Code)	
	and ealth m 27	1	Elesia Forrest/	spouse	T				oad 1	-	more, l	MD	21239			
nore	Pages 1 enf of H at: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☒ Donation 5 ☐ Other (Special Control of		20b. P	Place of Dispo emetery, crer	nsition (Na matory or i	me of other place	9)	Da	ate	20c. l	ocation - Ci	ty or To	own, State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Itams 23a or 28a-f show appriculty or other traumatic event, the Madical Examinar must be notified at ADEs.		21. Signature of Femeral Service Licensee Ronald S. Wante prector 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate													
	4 3		23a. Part LEnter the disease, or o	complications that caused	the deat							rrest			Approximate	9
			shock or heart lailure. List o Immediate Cause (Final	nly one cause on each lii	ne.							σσι,			Interval Bety Onset and I	ween
Ø,	Physician /Medical		disease or condition resulting in death)	a. EN Due to (or as	D	STAG	E	DE	YEr	1712	\			(nonu	tro
	Examiner														1 -	
2.		-	Sequentially list conditions, if any, leading to immediate	b. FAIC Due to (or as	2 CODERGE	(E	70	7H	KIU	E				a	ays	
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	,	d C										id and	
_	and and I-trar	хап	that initiated events resulting in death) Last	C. Due to (or as	•										0(0700	
8760,	cate be executed physicien and the burial-transit	alE				20.100 017.										
87	phys the	dic		d								· · · · ·				
9 X	The law requires that the death certifica tie has been signed by the attending pt page 2 should be detached for use as t	Physician/Medical	IF FEMALE:	23c. If yes, outcome	of oregon	ncv										
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Feta	Ideath 3	Ectopic p						23d. Date of Month		-	ear ear
o.	the d	ysk	1 Yes 2 No 9 Unknown	9☐ Unknown	tillia oi d	eatti 5	_ Other (s)	oecily)								
<u>Д</u>	that the death cer	Ph	Part II. Other significant condition	Is contributing to death b	ut not resi	ulting in the u	nderlying	CAUSA CIVA	n in Part	1	23e Did	tobacco	use contrib	ite to th	ne cause ol d	eath?
ds,	signe d be	1 by					,	g				Yes 2		Prob		Inknown
0	w requir been si should	etec														
Vital Record	e 2 s	Completed									24a. Was	psy	pric	or to cor	psy findings a ripletion of ca	available ause of
=	The pag	Ç									1 Yes	ormed2 N		ith? Yes	2□ No	
₩	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?							e of Death	(Check only	one)				
=	hysi his c	၉	1 ☐ Yes 2 ☐ No			ER/Outpatier			4 NI	ursing Hom	ne 5□Res	dence	6 Other	(Specif)	y)	
n	ng P	on:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Yea <i>r</i>)	28b. Time of Injury	f	28c. Injury Work	at ?	2:	8d. Describe	how inju	ıry occurred			
<u>Ş</u> .	Attending ir death. ector: After by the fune	atl	2 Accident investiga	ation			М	1 🗆 Y	'es 2 □	No						
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Place of Injury - At home, farm, street, lactory, office 28d. Place of Injury - At home, farm, street, lactory, office 28d. Place of Injury - At home, farm, street, lactory, office 28d. Place of Injury - At home, farm, street, lactory, office									81. Location (City or To	Street a wn, Stai	nd Number 'e)	or Rura	l Route Num	ber,		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner sta	f examina	wledge, death tion and/or in	h occurred vestigation	at the time n, in my op	e, date ar inion, dea	nd place, at	nd due to the d at the time,	cause(s) and mann nd place, and	er as st	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29	c. License	number			29d. D	ate signed (Month,	Day, Year)	
)			- FIL	ir MO			Do	005	531	O.		DE		20	7 700	20
			30. Name and address of person w	no completed cause of a	leath (Item	n 23a) (Tvne	Print)		ا د د			*	- 1	2/4	mhi=	0
			Sheleunmal		(n 23a) (Type,	san.	her	n.	000	dia	to	110	7	DZIC	71-
4,6	* Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	iture _			_ ,,,,		1		10		,	. ,
	Registr		DEC 2 7 2	805	J.	HOOM	Les J									

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of I	Marylan		artment rtificate			nd Mental	Hygien	2006	41207	
ı	Physici		Decedent's Name (First, Middle, Las Madeline Simi) Fineran							of Death	006 Year	3. Time of Death 7:00AM M	
	/Medic Examin		4a. Facility Name (If not institution, give 5320 Dorsey Hall				Elli	cott	Location of D			c. County of Death Howard		
	Funeral Director	5	5. Social Security Number 6. Sec. 78.03.3345 Usuel Residence of Decedent	Die orae	Age (In yrs. i	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min. 8. Date (Mont) (08/	of Birth Day, Yea 19/191	9. Birth 8 Balt:	place (State or Foreign pitry) LMORE, MD	
	a-f show	ctor	10a. State 10b. County Md Howard			y, Town or Lo Llicott		7					10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	th with th	ai Director	10e. Street and Number 5320 Dorsey Hall	Dr. Apt	318			042				USA	intry?	
2-0036	within 72 hours after death with the Maryland jene. 'Then "nature!', or items 23a or 28a-f show the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decede Amed Force 1 Tyes 2 If Yes, Give Year or Date	s? X No	'	Was Deced f Yes, spec 1 ☐ Yes 2	ify Cubar	spanic Origir n, Mexican, I Specify:	n? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - Amer Black, White Specify: Wh:	, etc.	
0-61212	within 72 ene. then "na'	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4)	or 5+)	life. I	dent's Usua kind of wor DO NOT us Make	k done d se retired)	urina most o	of working	16b.	Kind of Business/li Own I	,	
yland ,	id be filed ental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last) Gaudenzio Sim	i						s Name (First, M a Giann:		en Surname)		
, Mar	and 2 shoulealth and Mm 27 is marther treumati		19a. Informant's Name/Relationship (7 Madeline Rocheste			6389	Looki	ing (Lane. Co	olumbi	or Town, State, Zi a, Md 210	045	
saltimore,	r of H		20a. Method of Disposition 1 1 Disposition 2 Cremation 3 4 Donation 5 Other (Specify		rte Ft.		oln Ce	ther place emete		/28/2006	5 Br	entwood,	Md	
Pall	permit. Peg Department Important: i any njury o		21. Signature of Funeral Service Licen	Jeman	~	55	555 Tw	vin k	Molls	Rd. Co	Lumbia	1 Homes, , Md 2104	Inc. 45	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Muscalul Francher Due to (or as a consequence of): Sequentially list conditions, b. Utual Encaphulammenguts (Heupes type I)											
•	cate be executed physicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C. Pulman Followsis Due to (or as a consequence of):									24	
9/89	centificate be executed iding physicien and ise as the burial-transit	dicai	·	a Osteoporosis									10 yr	
O. Box	death e etter id for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ∏ Feta tat time of d	I death 3	⊒Ectopic pr ⊒ Other (sp					23d. Date of delin Month	very Day Year	
rds, P	signed signed d be de	þ	Part II. Other significant conditions c	ontributing to deat	h but not res	ulting in the u	nderlying c	ause give	en in Part I.	23e		·	the cause of death?	
Vital Records,		Completed								24a.	Was an autopsy performed Yes 2	prior to c	opsy findings available ompletion of cause of 2 No	
V 15	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	200	of Death (Check				
	Phys this ral dii	2	1 Yes 25 No	1 ☐ Inp		ER/Outpatier 28b. Time o		/A	4 14013	-		6 ☐Other (Speci jury occurred	ify)	
Division of	ding After fune	Certification:	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not by 4 Homicide determined	(Month,	Day Year)	Injury ome, farm, sti	М		res 2 □ No	o 28f. Loca		and Number or Ru	ral Route Number,	
ā	hours hours unerei	edicai Cert	29a. Certifier 1 1 Certifying Ph	ysician: To the b		owledge, deat				place, and due	o the cause	(s) and manner as		
	within 24 Within 24 To the Fi	edi	one)	and manne									· · · · · · · · · · · · · · · · · · ·	
	To the comple	Σ	29b. Signature and title of certifier	0.00		1		: License	number 100/66		11	Date signed (Month	/	
	7		30. Name and address of person who	completed cause	of death (lien	n 23a) (Type,		872	_ I	RA	mile	Medre	Me	
	St: Regist	ate	31. Date filed (Month, Day, Year)	2008 S	istrar's Signa	alure,	back				- /			

Fune Direc permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked of other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

/N	rsician ledical aminer

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician at Promotesby filled in by the funeral (incertor name 2 should has relaxered for use as the burial at

		For State Registrar	State of Maryla		epartment of H Certificate of I			ene g. No. 2	106	11208			
hysicia		FILE AND FIL											
/Medic Examin		4a. Facility Name (If not institution, gir Gilchrist Center	ve street and number)	Care	Towson	Location of Death		4c. County Balti	of Death				
uneral rector			Sex 7. Age (In yr		hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 18	,1959	9. Birthpl Count Mary				
-f show fled at	tor	10a. State 10b. County Maryland Baltimon			or Location			10d. Inside City Limits 1 □Yes 2¶No					
23a or 28a Ist be noti	Direc	10e. Street and Number 6316 Mt. Ridge Ro	1.		10f. Zip Code 21228				en of What Country? ted States				
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 □Yes 2 ☎ No If Yes, Give Year or Dates:	2 X No ive 1		Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto ☐ Yes 2☑ No Specify:		Bla	14. Race - American Indian, Black, White, etc. Specify: White				
than "natur he Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		- 1	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired structional	during most of work ii)	king	6b. Kind of B Educat		lustry			
rked other tic event, tl	To Be Co	17. Father's Name (First, Middle, Lass Robert Decker, St				18. Mother's Nam Helen Ma	e (First, Middle, M	aiden Surnar	ne)				
n 27 is ma ner trauma		19a. Informant's Name/Relationship Alfred B. Fultz	/ Husband	63	Mailing Address (Street 16 Mt. Ridge	e Rd., Ca	tonsvill						
rtant; If Iter njury or oth		20a. Method of Disposition 1 Burial 2 Oremation 3 4 Donation 5 Other (Spec	Removal from State	cemeter	Disposition (Name of y, crematory or other place Crematory	12 -3	0-06 C	atonsv	ille,	Maryland			
Impo any fr	2 Pint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her it failure. List only one cause on each line.												
sician edical iminer		Immediate Cau. (Final disease or con ition resulting in death)	a. Due to (or as a cons	sequence o) Cance	'V			C	Onset and Death			
rsician and e burial-transit	edical Examiner												
To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Wo 9 ☐ Unknow	23c. If yes, outcome pf preduced to the second sec	etal death	3 ☐ Ectopic pregnanc; 5 ☐ Other (specify) _	/			ate of delive	ry Day Year			
en signed b vuld be deta	by	Part II. Other significant conditions	contributing to death but not r	resulting in	the underlying cause giv	en in Part I.	23e. Did tob	- F	tribute to th	e cause of death? ably 4 □Unknown			
cate has be page 2 sho	Completed						24a. Was an autopsy perform 1∐ Yes 2	<i>'</i>	prior to con death?	osy findings available npletion of cause of 2 No			
ofter this certification	on: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year,	2 ER/Out 28b. T	ime of 28c. Injury Wor	er: 4 Nursing Ho y at k?	th (Check only one ome 5 Resider 28d. Describe hor	nce 6)10th	her <i>(Specif</i> y	nospice			
al Director: A	Certification	Accident investigation Accident investigation Could not determined	be 28e Place of injury - A		M 1 ☐	1 Yes 2 No							
the Funera	edical		Physician: To the best of my laminer: On the basis of exam and manner stated.		d/or investigation, in my o	opinion, death occu	rred at the time, da	ite and place	, and due to	the cause(s)			
To t	M	29b. Signature and title of certifier	Ma	7)	29c. Licens	8303	G 29	d. Date signe	ed (Month, I	Day, Year) 6 2006			
Sta	te.	30. Name and address of person who will be a second address of person address of	o completed cause of death (I	MA	. Charles	J7 BA	mune	un	217	060			
Registr	ar	DEC 2 7 20	Registrar's Signal	J. 18	part -								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dec Year **Physician** Kenneth Graves 405 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Muyland Medical Center
5. Social Security Numberunk 6. Sex 7. Age (In yrs. last bir Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 unk **Funeral** 1**∑**M 2□F Months Days Hours Director 38 Oct 23, 1968 Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1√2Yes 2□No Director MD Baltimore 10e. Street and Number 10f. Zip Code unk 10g. Citizen of What Country? with 2521 Brookfield Avenue USA Funeral filed within 72 hours after death unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Bleck, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: black ģ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau University of Md Hospital 22 S. Greene Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Sign in real Euneral Service Licensee Renald Wade State Anatomy Board 655 W. Baltimore Street Director 21201 m Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau Final disease or condition resulting in death) cerebrovascular accident **Physician** 2 weeks /Medical Due to (or as a consequence of): Examiner endolarditis 3 weeks Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Intrivenous drug physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical After this certificate has been signed by the attending I funeral director, page 2 should be detached for use as IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1∐ Yes 2. No 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient ို 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Records, ξ 13 or Vital To the Hospital or Attending Pleating 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral Division

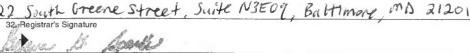
Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) DEC 2 2006

lonathan

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Flakel, MD

29d. Date signed (Month, Day, Year)

Dec 16,2006

06-09308

Cecil Alexander		I- For State	State of	Maryla	nd / Depa	rtment of		and M	lental Hy	ygiene	- 0.7		
	ı	Registrar 1. Decedent's Name (First,	Middle Last)			uncate of	Death			2. Date of Dea	eg. No.	3 Time	of Death
Physicia Medical Examir	111/4									Month Decembe			8 hrs
Umario		Cecil A. Gi 4a. Facility Name (if not ins	stitution, give s	treet and nu	mber)	Τ-	4b. City, Tov	n, or Loca	ation of Death		4c. County of	Death	
		444 Oxford Court					Baltimo	re					
Funeral		5 Social Security Number	per unk 6. Sex 7. Age (In yrs. last birthe			ast birthday)	If Under		Under 24Hrs.		of Birth(MM/DD/YYYY) 9. Birthplace (State		
Director				2 F	64	Yrs		Days	Hours Min.	Jan 19	Jan 19, 1942 Foreign Norti		
	Ŀ	Usual Residence of Deced	ent								,		
v any		10a. State 10b. Co	ounty		10c. City,	Town or Locat							side City Limits Yes 2 No
land f shov	ö	MD				ват	timor				10g. Citizen of What Country?		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 444 Oxford	Court				10f. Zip Co		1201	1	0g. Citizen of Wha USA	-	
th with cems 23	ᇒᆘ	11. Marital Status 1 Never Married 2		2. Was Dec Armed Fo	edent Ever in U. prces?				c Origin? (Sp xican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - White,	American India etc.	an, Black,
fter dea	y Fune	3 X Widowed 4	_	Yes, Give Yea	2 X No	1	Yes 2X	No sp	ecify [.]		Specify: 1	1ack	
ours a atura xamin	d b	15. Decedent's Education	(Specify only	highest grad	de completed)	16a. Deceden			Give kind of w		16b. Kind of Bus	ness/Industry	
6 72 h an "n cal E	ig [Elementary/Secondary (0-12)	College (1	-4 or 5+)	Quiling III	OST OF WORK	ig ilic. Do	1101 430 1011	104)			
5-0036 led within 7 Hygiene other than	Completed	6	• 1.11 - 1 1.	0		self	emp1o		latharia Nana	/First Middle	applian	ce repa	
215-0 be filed ntal Hyg rked oth		17. Father's Name (First, N	niddie, Last)				uı	AK 18.W	iotner's Name	(First, Middle, I	Maiden Surname)		unk
212 vuld be Menta mark	To Be	19a. Informant's Name/Rel	ationship (Type	e, Print)		19b. Mailing	Address (Street and	d Number or F	Rural Route Nur	nber, City or Town,	State, Zip Coo	de)
MD od 2 shoulth and Ilth and m 27 is		Angela Art	hur/dau	ighter		1011	Rebb	Cour	t Balt	imore,	MD 2120	2	
e, legh land land Healt litem	Ī	20a. Method of Disposition			20b F	Place of Dispos crematory or otl		of cemete	ry,	Date	20c. Location - 0	City or Town, S	tate
mol Pages nent of		1 Burial 2 Cred 4 Donation 5 X Ott			UIII State	,	, ,						
Baltimore, permit. Pages I an Department of He. Important: If ite		21 Signature of Funeral ROna	ervice License	ade, I	Directo				-		. Baltimo	ore Str	eet
Physician	-	23a Part I. Enter the disea	se, occomplica	ations that ca	aused the death.	Do not enter the	<u>ltimor</u> ne mode of c	e, M lying, such	D 212	OI r respiratory arr	est, shock, or hear	t Appro	ximate Interval
/Medical	1 30	Immediate Cause (Final di	cause on each	line.	otic Cardiov							Betwe	een Onset and Death
⊮ Examiner		or condition resulting in de	_		consequence of								_
· Salar	ē	Sequentially list conditions if any, leading to immediat	e Du	e to (or as a	consequence of	f).							
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O, e be executed ysician and burial - transit		events resulting in death)	d	` .									
0, e be executed sician and burial - trans	ledical	UNPENDED		AMENDED									
Sox 6876/ leath certificate e attending phy for use as the b	Ž	IF FEMALE: 23b. Was decedent pregna	nt in the	23c. If yes, 1	outcome of pregi		tal death	3 E	ctopic pregna	incy	23d. Date of d Month	elivery Day	Year
Box 6876 death certificat the attending phy	sician/M	past 12 months?	T Datases	4 Pregn	ant at time of de	- 41-	her (Specify)					
Bo he dear	2	1 Yes 2 No 9	Unknown	9 Unkno						100 D II			
P.O. es that the igned by be detac	질	Part II. Other significant of Chronic Ethanoli		ontributing to	o death but not re	esuiting in the L	inderlying ca	iuse given	in Part I.		obacco use contrib s 2 No 3		
ords, w requir	Completed									24a. Was autop		ere autopsy fin or to completio	dings available
Vital Recol hysician: The law this certificate has I director, page 2 si	Ĕ				·						rmed? de	ath? ✓ Yes	2 No
Vital Rec sysician: The this certificate director, page	S -	25. Was case referred to n	nedical				26	Place of D	eath (Check				
Vita ysicia ysicia direct	m	examiner? 1 ✓ Yes 2 N	Hos	pital: 1 1	inpatient 2	ER/Outpatient	3 DO/	Othe	er: 4 Nursin	ng Home 5	Residence 6	Other: Scene	
n of ling Ph	諨	27. Manner of Death		28a. Date (Month	of Injury , Day, Year)	28b. Time of I	· ·	. Injury at		28d. Describe	how injury occurred	<u> </u>	
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Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should l	ertification:	3 Suicide 6	Could not be determined	28e. Plac (Specify)	e of Injury - At ho	ome, farm, stre	et, factory, o	ffice buildi	ng, etc.	28f. Location (3 or Town, S	Street and Number State)	or Rural Route	Number, City
lospit 4 hour uners	O	4 Homicide 29a. Certifier 1 Certify				ge, death occur	red at the tir	ne. date a	nd place, and	due to the caus	se(s) and manner a	is stated.	
To the Hos within 24 h To the Fur completely	Medical		al Examiner: 0		of examination a						and place, and du		s)
F . W C .	Re	29b. Signature and title of	_	A M	. 24		29c. L	icense nu	mber		29d. Date signed	(Month, Day,	Year)
		Allessa &			D.C.M.E			December 7	, 2006				
		30. Name and address of p	person who cor	rson who completed cause of death (Item 23a)									
		Melissa Brassell,		.6	dical Examir egistrar's Signati			ei, baiti	more, IVID	Z Z U		-	
St Regist	ate rar	31. Date filed (Month, Day	772006	F 4 22	See A	ire	Sand?						

	20		1- For State of Marylan	d / Depa	artment of	Health f Deat	and M		ene 006	41211	
3	Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Yea	3. Time of Death 2504 M		
	/Medic	al	Darriol Paul Gagnon 4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			22-06 4c. County of De		
44.6	Examin	er	Carroll Hospital Center		Westminster				Carroll		
7 . S	Funeral	**	5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Ye Months Dar	ar If Und	er 24 Hrs.	8. Date of Birth	9.8	irtholace (State or Foreign	
	Director		392-12-0806 ¹ ₹ ^{M 2□ F} 85	Yrs.				Aug 6, 1	.921	MN	
	/land	ctor								10d. Inside City Limits	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Items 23a or 28a-f show amportant: If Item 27 is marked other than "natural," or Items 23a or 28a-f show any figury or other traumatic event, the Medical Exemples could be collined at once.		MD Carroll Westminster						1 ☐ Yes 2 No		
		Director							g. Citizen of What	Country?	
		erai	808 William Avenue 11 Marital Status 12. Was Decedent Ever in U.	C 12 1	Was Decedent of Hispanic Origin? (Specify Ves or No.				USA	nerican Indian,	
(0		Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes, Give Λ 1 □ Yes, Give Λ	If Yes, specify Cuban, Mexican, Puerto Ri				Rican, etc.)	Black, Wi	Black, White, etc.	
93		ρ	3 ₹ Widowed 4 □ Divorced If Yes, Give ↑ Year or Dates:		1 ☐ Yes 2 ☐ No Specify:				Specify: White		
5		To Be Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Oc kind of work do	ne durina m	nost of workin	ng 10	6b. Kind of Busines	s/Industry	
21215-0036			Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) Electrical Engineer Electrical						ra1		
b			17. Father's Name (First, Middle, Last)					(First, Middle, Ma			
<u>ylar</u>			Paul Gagnon				Georgianna (Unknown)				
Mar			19a. Informant's Name/Relationship (Type, Print) Mr. Neil T. Gagnon (Son)		-				City or Town, State .e,MD 21		
<u>6</u>	Healt Healt tem 2 othsr		20a Method of Disposition 20b. P	lace of Dispo	sition (Name of				Oc. Location - City of		
OE.	permit. Pages Department of Important: If It any injury or once.		1 YBURAL 2 Uremation 3 Hemoval from State		Mem. G		s 12/2	8/06 F	inksburg	. MD	
Baltimore, Maryland			21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400								
	The law requires that the death certificate be executed with the death certificate be executed with the attending physician and be detached for use as the burial-transit are as the burial-transit.	ai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								
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			cause. Enter Underlying Cause (Disease or injury that initiated events c.								
8760,			resulting in death) Last Due to (or as a consequence of the control of the contro	uence of):	.nce of):						
687	ficate physics the	edica	d								
Box 6	that the death certific ed by the attending p detached for use as	Aedical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant		th 3 DEctopic pregnancy				23d. Date of delivery		
B			in the past 12 months? 1					Month Day Year			
cords, P.O.	that the ed by detacl									to the cause of death?	
	w requires that been signed should be det							1 Yes 2 No 3 Probably 4 Unknown			
	aw rec is bee 2 shou							24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No			
m m	cian: ertifica ector, I									•	
Division of Vital Records,			25. Was case referred to medical examiner?					(Check only one)			
			1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								
			1 Natural 5 ☐ Pending (Month, Day Year) 2 Naccident investigation	Injury							
Vis			3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hombuilding, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
ō											
			29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
		Σ	29b. Signature and title of certifier	2		onse numbe)	1. Date signed (Mo.		
	Λ		30 Name and address of person who completed cause of death (Item 23a) (Type Print)								
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO, MD 200 MEMORIAL AVENUE, WESTMUSTER, MD 21157								
	Sta Registr		31. Date filed (Month, Day, Year) 32. Degistrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 15:59 PM GIRSHMAN ISAY 24 2006 December /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Sinai Hospital Baltimore N/A of If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 0376671939 100 M 2□ F RUSSIA 216-23-0160 67 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show ed other then "natural", or Items 23s or 28s-f shovevent, the Medical Examiner must be notified at 1 ¥ Yes 2 □ No MD N/A BALTIMORE Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21215 3615 FORDS LANE #412 death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No II Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify: Specify Completed by 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) ELECTRICAL ENGINEER ENGINEERING marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Pages 1 and 2 should be inner of Health and Mental **GOLDENBERG** GIRSHMAN **ESTHER** ISRAEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3615 FORDS LANE #412 - BALTIMORE, MD 21215 ADELAIDA GANETSKAYA / WIFE item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 'Department of Himportant: If ite eny injury or of pages. 1 Burial 2 Cremation 3 Removal from State HAR SINAI CEMETERY 12/26/2006 OWINGS MILLS, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cuta myocande resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 ☐ Live birth 2 Fetal death Year Month Day ō 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 3 Probably 4 Minknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 2 No 1 ☐ Yes 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient ٩ 3 DOA nours after death.
Inerel Director: After this y filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide within 24 hours a
To the Funerel C f 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 33 December 24, 2006 /chas M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West Belvedere tvenue, Balkimore, Maryland 2401

DHMH 17 Rev 1/2001

State

Registrar

MAHAJABIN

31. Date liled (Month, Day, Year)

32. Registrar's Signature

2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death Month Day Year **Physician** 0100 1 12/22/06 1630 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Linthicum Inder 1 Year | If Under 24 Hrs. Anne Arundel 541 Cleveland Rd. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Min Director 82 3/24/1924 Pennsylvania 194-14-6642 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar many force. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes XXNo Directo Carroll Reisterstown MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21136 2333 Elderberry Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Curry 2 Wallace Lutton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2333 Flderberry Dr., Reisterstown, MD 21136
pate | 20c. Location - City or Town, State <u>Bruce Havlicsek/son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/28/2006 <u>Grandview Cemetery</u> Pennsylvania 22. Name and Address of Facility 21. Signature o Funeral Service Licensee Gary L. Kaufman Funeral Home @ MMP, Inc. 7250 Washington Plvd., Flkridge, MD plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 21075 Approximate Interval Between Onset and Death 23a Part. Enter the dise to snock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a) onsequence of): Examiner nary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a cons Division or Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? 1 Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Hospital or Attending Injury 1 Natural 5 Pending investigation 1 Tyes 2 🗌 No 2 Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of Aertifier empleted cause of death (Item 23a) (Type, Print) Name and address of person who NNPOLIMO 2140 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 24, 2006 Charles Alfred Harris 11:55 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Pikesville 4c. County of Death Baltimore Examiner North Oaks Retirement-Health Center 8. Date of Birth Feb. 27, Year) 911 Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours 216-05-2509 1 XM 2 ☐ F 95 Mafwiand Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10c. City, Town or Location 10d. Inside City Limits Baltimore Pikesville 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21208 725 Mount Wilson La., #228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Completed by Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Oil 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arabella Townsend Harris George 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 48th St., Baltimore, MD 21224 19a. Informant's Name/Relationship (Type. Print) Deborah A. Harris-grandaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Srv Corp Towson, MD 12/27/2006 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Month Year 5 Other (specify) 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted To the mosphore.

within 24 hours after death.

To the Funeral Director: After this c 1 ☐ Yes 2 No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Miller 25 Main Street Smile 200 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

DEC 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year 9:23AM Hariu December 22 /Medical 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown North west Hospital Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 7, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🙀 F NY Yrs. 120-14-1227 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll Sykesville 1 ☐ Yes X ☐ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Nidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gustav Arthur Goerger ٩ Anna M. Whiting 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susan F. Cooke (Executor) 4156 Louisville Rd., Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation | 12/28/06 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Buan Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxic brain /Medical Due to (or as a consequence of): **Examiner** Iseless electrical cardiac arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner cardiomyopain Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760; Physician/Medical Coronary arter IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 □Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by chronic kidney disease 2 No Anemia 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Dement 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Stage, III chronic kidney disease this certificate Metabolic hone disease 25. We case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician: The law requires that the death certificate be executed ours after death.

neral Director: A
filled in by the fu within 24 hours a To the Funeral L

n

Medical

29a. Certifier

29b. Signature and title of certifier

State Registrar

Northwest Boston Hospital 31. Date filed (Month, Day, Year)

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Center Randallstown, Maryland 21133 32. Registrar's Signature Good

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D28462

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

06-09746 Wesley Harris

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day December 21, 2006 1320 hrs **Medical Examiner** Wesley Howard Harris 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore University Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6 Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Foreign Days Hours Director Country) $_{1}$ X_{M} 23 Yrs 08/24/1983 2 F MD 215-04-1996 Usual Residence of Decedent 10d Inside City Limits 10b County 10c. City, Town or Location 10a State 1 X Yes 2 No or 28a-f show MD Baltimore items 23a or 28a-f shotust be notified at once. with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2407 Lauretta Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces⁴ 1 X Never Married 2 Married Yes SpecifAfrican American 1 Yes 2 X No specify: If Yes, Give Year th and Mental Hygiene n 27 is marked other than "natural", umatic event, the Medical Examiner ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 ! 21215-0036 unknown unknown 11th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Hoawrd Harris, Sr. Renee' Ferguson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٥ Joyce Harris / Aunt 2407 Lauretta Avenue; Baltimore, Maryland Department of Health at Important: If item 27 injury or other trauma 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 12/29/2006 Baltimore, Maryland Mount Zion Cemetery Donation 5 Other Specify Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 2 638 N. Gilmor Street; Baltimore, Maryland Approximate Interval complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I Enter the disease, or Physician Between Onset and failure. List only one cause on each line. /Medical Death Multiple Gunshot Wounds Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last that the death certificate be executed sician/Medical physician a UNPENDED AMENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o è 1 Yes 2 No 3 Probably 4 V Unknown مَ Completed Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autonsy has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: of Vital Be Other₄ examiner? DOA Inpatient 2 V ER/Outpatient 3 Residence 6 this 1 🗸 Yes ဥ No 28d. Describe how injury occurred 28a. Date of Injury FOUND: 28c. Injury at Work? After Manner of Death 28b. Time of Injury Certification: Subject shot FOUND: Division Natural 1 Yes 2 V No 5 Pending death the To the Funeral Director: Dec 21, 2006 1244 hrs Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) 2400 Block Winchester Street, Baltimore, MD (Specify) Local Street determined 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. December 22, 2006 Name and address of person who completed use of deat (Item 23a) 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ecember 17,2006 homas IAMES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** aryland tal Greneral 7/2 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Months Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 218-01-330264 1**X**M 2□ F Hours Min. Ó UNE 23 1947 Director MARY land Usual Residence of Decedent 10a State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 Yes 2 No Funeral Director MA MARLIAND with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 USA mt. 21216 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **№** No 3altimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify Specify; AMERICAN Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) DI Sable 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blossie 2 lhomA5 MaE 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Court-Apt. 6 BALTIMICEE MARYLAND 21234 LENA ToloRis Pages 1 a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State December 29 2006 Bathmore Megland Minner. NATIONAL 4 Donation 5 Dother (Specify) 22. Name and Address of Facility FURRAL SERVICE NAMEY M. WALLACE FURRAL SHOOT BALLIMORE. re of Funeral Service Licer MARIMAN 2/329 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, learning to infriedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the burial-tran and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manufer of Death funeral 28a Date of Injury 28h Time of 28d. Describe how injury occurred After (Month, Day Year) 5 Pending investigation death. s a er death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 🍼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

Registrar

State

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11 Heratel

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 9:20P^M Faith Dec 24 Johnson 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Care @ Sykesville Continuum Sykesville Carroll If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 K F 213-16-3605 July 11 1922 Texas Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2XXNo Sykesville Funeral Director MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7309 2nd Ave. 21784 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after deat lopartment of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or Items; any injury or other traumatic event, the Medical Examiner mu any injury or other traumatic event, the Medical Examiner mu 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes XX No Maryland 21215-0036 Yes. Give ģ 3 ☐ Widowed 4 ☑ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Silver Spring Inn Waitress 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Prigodich Stephen Seluzetsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Harriett L. Pfister Daughter 645 Basehoar School Road Littleston, PA 17340 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State South Carroll Crematory Dec. 27, 2006 Winfield, MD 4 □ Donation 5 □ Other (Specify) 21. Sign tun of Funeral Service 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MP Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause and line. Apor x Interval Between Onset and Death Immediate Cause (Final Physician ponentia ng in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liceas of ir ju.) that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No page 2 1□ Yes Hospital or Attending Physician: 26. Place of Death Check onl one 25. Was case referred to medical examiner? director, Be Other: 2 No 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 1 🗌 Yes 1 Inpatient Certification: To 28b. Time of 28d. Describe how injury occurred funeral 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License numbe 29d. Date signed (Month, Day, Year) 29b. Signature aportitle of contifier who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Physician /Medical Examiner

death with the Maryland

filed within 72 hours after

altimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked of

physician and sthe burial-trans as use þ ed by the a cate has been signed by page 2 should be detacl

The law requires that the death certificate be executed

the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760.

Completed Be Certification: To

Medical

1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4⊟Pregnant at time of death 9⊟Unknown				
art II. Other significant con	ditions contributing to de	eath but not resulting	in the underlying	cause		
RECENT	CORONARY	ARTER	BYPASS	W		

28a. Date of Injury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 1 11 100	TE 168 21 NO SE PIODADIY 4 OIKIOW	711					
	24a. Was an autopsy findings availab prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No	le					
26. Place of Death	(Check only one)						
Other: 4 Nursing Hom	ne 5 ☐ Residence 6 ☐ Other (Specify)						
Injury at Work? 1 Yes 2 No	8d. Describe how injury occurred						
fice 28	8f. Location (Street and Number or Rural Route Number, City or Town, State)						
he time, date and place, a	nd due to the cause(s) and manner as stated	_					

DECEMBER 19 2006

d due to the cause(s)

1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes	2 🗆 No			
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At ho building, etc. (Specify	28f. Location (Street and Number or Rural Route N City or Town, State)					
29a. Certifier (Check only one)	1 Certifying Physi 2 Medical Examin	iclan: To the best of my known er: On the basis of examination and manner stated.	wledge, death occurr tion and/or investigat	ed at the time, d ion, in my opinio	late and place on, death occu	e, and due to thurred at the tim	ne cause(s) and manne e, date and place, and	er as stated. I due to the cause
29b. Signature and	title of certifier			29c. License nur	mber		29d. Date signed (A	Month, Day, Year)
	1/4/	PHYS	ician	4005	5834	9	DECEMBER	19 2001

28b. Time of

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

State Registrar

EDMUND PORT, DO. 31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

32 Registrar's Signature

201 E. UNIVERSITY PARKWAY BALTIMORE MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 24, Physician December 6:30 PM 2006 Theressa Jane Jones /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll 2511 Cillis Road Mt. Airy If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Country) 1941 Months Hours 1 M 2 F 65 Dec 215-40-4438 6. Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deparlment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ▼No Director MD Carrol1 Mt. Airy 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21771 2511 Gillis Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗓 No White Specify Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Asst. Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Alice Theressa Lewis William Robert Tyree 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2511 Gillis Road, Mt. Airy, MD 21771 Mr. Kenneth Jones (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 12/26/2006 Sykesville, MD 21. Signature of Funeral Service Licensee TATCHT AFUNERALLY HOEM & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) the dearer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): ed by the attending physician detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 K No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗖 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has certificate 1□ Yes 2No 25. Was case referred to medical examiner? 1 ☐ Yes 2 No Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Hospital or Attending Physician: elaw requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death within 24 hours a

To the Funeral I

completely filled To the

Baltimore, Maryland 21215-0036

State Registrar

29a. Certifier

(Check only one)

30. Name and address

31. Date filed (Month

29b. Signature and title of certifie

AFRIC Year)

2006

DHMH 17 Rev 1/2001

of person who completed cause of death (Item 23a) (Type, Print)

195

Registrar's Signature

🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

06-09757	
Erik Johnson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ik Johnson		State of Maryland / For State egistrar		tificate of D		illai nyg		g. No.	6 4122
Physician ledical Examine	1	Decedent's Name (First, Middle,Last) Erik Johnson					Date of Death Month December		3. Time of Death 1002 hrs
	4	a. Facility Name (if not institution, give street and number) University Hospital			City, Town, or Locatio Saltimpre	n of Death		4c. County of Death	
Funeral Director		218-80-1269 1 ^X M 2 F	(In yrs. la		f Under 1 Year If Under 1 Year		8. Date of Birt	h(MM/DD/YYYY) 9. Bir Foreig 972	
any	_	Usual Residence of Decedent Oa. State 10b. County	10c. City,	Town or Location					10d Inside City Limits
Maryland 28a-f show at at once.	<u>.</u>	MD Oe. Street and Number		11	Baltimore Of. Zip Code		110	g. Citizen of What Cou	1 Yes 2 No
the Maryland a or 28a-f sh tified at once	3	1542 Payson Street			21216			USA	,
and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygens tem 27 is and the other than "natural", or items 23a or 28a-f She traumatic event, the Medical Examiner must be notified at once	unera	1. Marital Status 12. Was Decedent Armed Forces? 1 Yes 2	Ever in U.	If Yes,	ecedent of Hispanic C specify Cuban, Mexic	an, Puerto Ri	offy Yes or No- can, etc.)	White, etc.	can Indian, Black,
rs after	<u></u> }-	Widowed 4 Divorced of Divorced of Dates: 15. Decedent's Education (Specify only highest grade com	pleted)		s 2 No speci		k done	SpecifAfrica 16b. Kind of Business/	n American
hin 72 hou le than "nat than "nat edical Exa	nalaldillo	Elementary/Secondary (0-12) College (1-4 or 5		during most	of working life. DO NO salesman	OT use retired	4)	unknown	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygener Important: If item 27 is marked other than injury or other traumatic event, the Medical Table Commodition of the Commodity of the Co	5	7. Father's Name (First, Middle, Last)						faiden Surname)	
and 2 should be fi lealth and Mental is tem 27 is marked traumatic event,	0 0	Roland Johnson 9a. Informant's Name/Relationship (Type, Print)		19b Mailing A	ddress (Street and N		Cynthia ral Route Num	Archer ber, City or Town, State	, Zip Code)
MD shot and lith and may ris aumatic		Tiffany R. Johnson / Sister			oodnow Road;				
timore, MD The Pages and 2 sh The Sheath an Trant: If item 27 i	- 1	20a. Method of Disposition 1 $ ilde{X}$ Burial 2 Cremation 3 Removal from Sta	ite	crematory or other			Date	20c. Location - City or	,
Baltimore, Department of Hee Important: If ite	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	Ar	butus Memor 22. Nam	cial Park e and Address of Fac	12/27		Baltimore, Ma Funeral Home,	
	1	23a. Part I. Enter the disease, of complications that caused	4b 4b				; Baltin	nore, Maryland	
Physician /Medical 5xaminer	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunsho	t Wour	nds	node or dying, such a	s cardiac or r	espiratory arre	sst, shock, of heart	Between Onset and Death
,	-1	or condition resulting in death) Due to (or as a consessed provided by the conditions,	equence o	т):					
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	equence o	of):					
	Щ Ж	events resulting in death) Last Due to (or as a conse	equence o	of):					
be evectivities and an arrival - tr	Medical	UNPENDED AMENDED							
Records, P.O. Box 68760, The law requires that the death certificate be evecuted teate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Physician/Me	IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcor 1 Live birth 4 Pregnant at		2 Fetal	death 3 Ecto	opic pregnanc	су	23d. Date of deliver Month	y Day Year
that the de hed by the detached f		9 011110411	but not r	esulting in the und	erlying cause given in	Part I		bacco use contribute to	
ords, P.O. v requires that the speen signed by should be detact	ed by						1 Yes	n 24h Were a	topsy findings available
Division of Vital Records, tal or Attending Physician: The law requirers after death. The Director: After this certificate has been so the dinector, bage 2 should have in by the funeral director, page 2 should be a should	Completed						autop	sy prior to death?	completion of cause of
ital sician:	å	25. Was case referred to medical examiner? Hospital: 1 Inpatie	ent 2 🗸	ER/Outpatient	26.Place of Dea		-	Residence 6 Othe	r:
on of V nding Phy th. r: After th	ion: To	1 ✓ Yes 2 No	irv	28b. Time of Inju 0925 hrs		9	8d Describe ubject sho	now injury occurred	
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Lou			factory, office building		or Town, S	Street and Number or Ri state) North Monroe Street,	
To the Hospi within 24 hou To the Funer completely fi	Medical C	29a. Certifier 1 Certifying Physician: To the best of mone) Medical Examiner: In the basis of examiner one	y knowled mination a	dge, death occurred and/or investigation	d at the time, date and n, in my opinion, death	place, and d	ue to the caus the time, date	se(s) and manner as sta and place, and due to the	ed. ne cause(s)
To To	Me	29b. Signature and title of certifier			29c. License num	ber		29d Date signed (Mo	
TY I		30. Name and address of person who completed cause of o	leath (Iter	n 23a)	O.C.M.E.			December 23, 2	
3		Mary G. Ripple MD. Deputy Chief Medi	cal Exa	miner 111 i	Penn Street, Ball	timpre, MI	21201		
Sta Registr		31. Date filed (Month, Day, Year) 32. Registra	ır's Signat	ture Sparke	,				

			1 - For State Registrar	State of Marylar		artment of H		, ,	ene g. Ng2 0 0 6	41222
ı	Physici /Medic		1. Decedent's Name (First, Middle, La Edward Kilson	st)				2. Date of Death Month December	Day Year 2006	3. Time of Death 8:45 PM ^M
	Examin		4a. Facility Name (If not institution, given				Location of Deat	h	4c. County of Death	1
-			Joseph Richey H 5. Social Security Number 6.5		. last birthday)	Balti If Under 1 Year	more If Under 24 Hrs	9. Date of Birth	0.0	- Change Foreign
	Funeral Director			1 M 2 □ F 86	Vrc	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 28		place (State or Foreign intry) yland
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Sa-f s	Director	MD		Ва	altimore				1 √ Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	s 23e	erai	501 W. Franklin	Street 12. Was Decedent Ever in U	16 12		1201	Casalia Van es No	USA 14. Race - Amer	ione Indian
	r item	Funerai	11. Marital Status 1 ☑ Never Married 2 ☐ Married	Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	in, Mexican, Puer	to Rican, etc.)	Black, White	, etc.
ğ	be filed within 72 hours after death with the Maryland stal Hyglene. Id other than "natural", or items 23s or 28s-f show event, the Medical Exeminar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:		Specify: b1	ack
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121	within 300.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired				
2	filed Hygie other	e Co	17. Father's Name (First, Middle, Last	0		disal unk		me (First, Middle, M	none aiden Sumame)	unk
Maryland	2 should be and Mental is marked o	To B								unk
ary	s 1 and 2 should f Health and Men Item 27 is marke other treumatic		19a. Informant's Name/Relationship	Туре, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ural Route Number,	City or Town, State, Zi	p Code)
	123 g		Dawn Cherry/nie				n Street	Baltimor		1.7
altimore,	Pages 1 ament of Heament: If item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 ₩ Other (Speci	Removal from State	cemetery, crei	osition (Name of matory or other plac	:e)	Date 2	0c. Location - City or T	own, State
Balt	permit. Pages Department of Importent: If it eny injury or once.		21. Signature of Funeral Service Lice			Name and Address ate Anato altimore,			Baltimore :	Street
760,	/Medical Examine and parigificans and parigificans and parigificans it seems to be provided as the provided as	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of Due to (or a consect of Due to (or a consect of Due to (or a consect of Due to (or a consect of Due to (or a consect of Due to (or a consect of Due to (or a consect of Due to (or a consect of Due to (or a consect of Due to (or a consect of Due to (or a consect of Due to (or a consect of Due to (or a consect of Due to (or a consect of Due to (or a consect of Due to (o	quence of):	OF Fr.	VASTE	QUIN.	MITS I	Interval Burween Onser and suth
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ecords, P.	quires that n signed b uld be deta	á	Part II. Other significant conditions	contributing to death but not re-	sulting in the u	nderlying cause give	en in Part I.		acco use contribute to	the cause of death!
ဝ လ	aw requir. Is been si 2 should l	piete	Theumon	MI				24a. Was an	4b. Were aut	opsy findings available
Y		Completed	//					autopsy perform	ed? death No 1 as	ompletion of cause of 2 No
Vital	certifical rector, p	Be (25. Was case reference medical examiner?					ath (Check only one	-	- Ho . and
ō	ing Phys After this uneral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 🗆 Nursing r	lome 5 Residen 28d. Describe how	ce 6 Other (Speci v injury occurred	HUDICE
Division	al or Attend s efter death il Director: , ad in by the f	Certification:	3 Suicide 6 Could not determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospital or A within 24 hours efter To the Funeral Direcompletely filled in by	Medical (29a. Certifier 1 Certifying PI (Check only one) 1 Medical Example	nysician: To the best of my kn miner: On the basis of examinated.	owledge, death ation and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	e, and due to the cau irred at the time, dat	use(s) and manner as see and place, and due t	stated. to the cause(s)
1	To ti To ti Comp	Σ	29b. Signature and title of certifier	Burn		29c. License	e number	29	d. Date signed (Month,	pay, Year)
L			11/11/11/11/11	MINNE		UK	20/2	- /-	2/14/1	0
		ļ	30. me address of so who	comp ted cause of death (Ite	my23a) (Type,	Print)	RIB.	the 1	11 71	7/8
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature 6	1000 1	H DO	110/ 174	1 40	43
	Registr		DEC Z (.UUD	D A	Sell J				

for State Registrar		Department of H Certificate of I			No.2006	41223		
1. Decedent's Name (First, Middle, Las Physician Mary C. Kearne				2. Date of Death Month December	21, 2006	3. Time of Death 9:45 P M		
/Medical Examiner 4a. Facility Name (If not institution, give House of Jubilee		1	Location of Death		4c. County of Death			
Funeral 5. Social Security Number 6. S		birthday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye anuary13,	Q Righ	place (State or Foreign intry) Limore, MD		
Usual Residence of Decedent 10a. State 10b. County MD Harford		own or Location				10d. Inside City Limits 1 □Yes 2 ♠No		
the with the war and Number with the war and Number 2506 Palmer View	Dr.	10f. Zip Code 21015			Citizen of What Cou JSA	ntry?		
Debattiment of Health and Number 2506 Palmer View MD	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	ispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Ameri Black, White, SpecifyWhit	, etc.		
Total Secondary (0-12) Total Secondary (0-12) Total Secondary (0-12) Total Secondary (0-12) Total Secondary (0-12) Total Secondary (0-12) Total Secondary (0-12) Total Secondary (0-12) Total Secondary (0-12)	de completed) College (1-4or 5+)	6a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired Secretary	durina most of workin	g Fe Wa	Kind of Business/Ir Ederal Gov or Departm	ernment ent		
Walk and Mark (First, Middle, Last) 17. Father's Name (First, Middle, Last) Charles Norman C. 19a. Informant's Name/Relationship (Melissa Ziberste.)		Joseph	18. Mother's Name Mary The	(First, Middle, Maid erese Fla				
of some state of the second state of the secon	in-Daughter 2	9b. Mailing Address <i>(Street</i> 2506 Palmer V.	iew Dr. Be	elair, MD	21015	,		
20a. Method of Disposition 1	Removal from State Park	e of Disposition (Name of etery, crematory or other place Wood Cemetery	12/27	/2006 Par	kville, M	D		
21. Signature In eral Service Licer		Belair 3 N						
Physician Immediate Cause (Final disease or condition	disease or condition a. 1/c hy dita how							
Examiner Sequentially list conditions	Due to (or as a consequence b.					weeks		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?								
The law requires that the death conflicts that	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal der 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 ☐ Ectopic pregnancy	,		23d. Date of deliv Month	rery Day Year		
Sp and a depth of the significant conditions of the significant co	contributing to death but not resulting	g in the underlying cause give	en in Part I.	23e. Did tobacc	co use contribute to t 2 X No 3 □ Pro	the cause of death?		
Sician: The law requires that the de sician: The law requires that the de certificate has been signed by the conditions of the conditions				24a. Was an autopsy performed 1 Yes 2 🔀	prior to co death?	opsy findings available ompletion of cause of 2 ☐ No		
25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpationt 3E DOA Oth	26. Place of Death		o 177011 10	ity) Assisted Livi-		
	28a. Date of Injury (Month, Day Year) 28t	b. Time of lnjury 28c. Injury Work		8d. Describe how in		N) WSISHOCK ETON		
The part of the pa	28e. Place of injury - At home, building, etc. (Specify)	, farm, street, factory, office	2	8f. Location (Street City or Town, St	t and Number or Rur tate)	al Route Number,		
thin 24 hour thin 25 hour thin 24 hour thin 25 hour thin	nysiclan: To the best of my knowled miner: On the basis of examination and manner stated.	and/or investigation, in my o	ppinion, death occurre	ed at the time, date	and place, and due	to the cause(s)		
29b. Signature and title of certifier 29b. Name and address of person who	ay mo	29c. Licens	e number	29d.	Date signed (Month,			
30. Name and address of person who wand K-loesz State Registrar 31. Date file Month, Day, Year) DEC 2 7 2	completed cause of death (Item 23: m 5 (2 7-0) A 32 Registrar's Signature	a) (Type, Print) (Charles Sh	Suile 42	02 76h	us an Mo			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:20AM December 22 2006 James W. Kemp /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner aint Agnes Huspital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/25/1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**Z**M 2□F Maryland Yrs. 212-28-0038 78 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 829 South Ridge Rd. 21228 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Agent Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James W. Kemp Lola Inglehart ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jo Anne Kemp - Wife 829 South Ridge Rd. Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cem. 12/29/2006 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Tuneral Service Lice 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home, Inc 11630 Edmondson AVe. Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Irreversible Septic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence of) ingmes W Kemp Division or Vital Records, P.O. Box 68760 Physician/Medical as the l attending properties of the second IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) n signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinsonism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death. To the Funeral Director; After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10

State Registrar

31. Date filed (Month, Day,

RAGAI

MEENA

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900s Caton Avenue , Baltimore, MD

P18617

December, 22, 2006

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Donald LeFevere 9:30 December 18, 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7916 Charlesmont Road Dunda1k Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1**∑**M 2□F 218-62-4658 53 June 14, 1953 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2↓ No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7916 Charlesmont Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Margaret Hoopes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7916 Charlesmont Road Dundalk, MD Margaret LeFevere/mother 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Sign, ture Funeral Service Licensee Rona S, Wade, Mirector mm Baltimore, MD 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Care (Final ANCREATITI S CHROMC disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ABETES Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No 9□Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes |2 ☐ No 3 ☐ Probably 4 ☐ Unknown RIGLY CERIDEM 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes PINo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hesidence 6 Other (Specify) Hospital: 1 Inpatient 1 Tyes 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner certificate be executed Division or Vital Records, P.O. Box 68760, physician the as attending p detached ģ has

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

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Completed by

Be

Medical Certification: To

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed wii Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, the jonce.

Physician

/Medical

hours after

Baltimore, Maryland 21215-0036

page 2: certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

DHMH 17 Rev 1/2001

State Registrar

M. 31. Date filed (Month, Day, Year)

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one) determined

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

1224

			1 - For State Ragistrar	State of Maryla	-	artment of <i>tificate o</i>		_	giene Reg. No. 2006	41226	
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of De. Month	Day Year	3. Time of Death	
	Physici /Medic		Edward Henry Lewis						er 26, 2006		
	Examin	ner	4a. Facility Name (If not institution, give s. Knollwood Manor Nu			4b. City, Town	or Location of Deasoville		4c. County of Dea		
	Funeral Director		5. Social Security Number 6. Sex 217–38–4516	M 2□F 7. Age (In yrs 64	. last birthday) Yrs.	If Under 1 Yes Months Day		(Month Da	th y, Year) 9. Bir 2, 1942 Mai	thplace (State or Foreign ountry) cyland	
	pud *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits	
	death with the Maryland ime 23a or 28a-f show f nitted for thatflight at	5	Maryland Anne Aruno		en Burn					1 ☐ Yes 2 🙀 No	
	the r	Directo	10e. Street and Number			10f. Zip Code	9		10g. Citizen of What C	ountry?	
	h with		7882-T3 Americana	Circle		2106	0	1	United Stat	es	
350	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylian Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Married	2. Was Decedent Ever in 0 Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify C 1 ☐ Yes 2 🛛 N	of Hispanic Origin? (uban, Mexican, Pue No Specify:	Specify Yes or No irto Rican, etc.)	14. Race - Am Black, Whi	te, etc.	
213-0030	within 72 hours after ene. then "natural", or Ite te Medical Examina	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work do DO NOT use ret	ne durina most of w	orking	16b. Kind of Business	/Industry	
N	ygien ygien ygien t, the	Con	10		Estim	ator	1	(F) 1 AC 41	Glass Co	mpany	
yland	tal H d off	Be	17. Father's Name (First, Middle, Last) Unknown				Unkno		Maiden Sumame)		
	hould d Mer marke matic	ဌ	19a. Informant's Name/Relationship (Typ	oe. Print)	19b. Mailir	ng Address (Stre			er, City or Town, State,	Zip Code)	
Z	Ith an 27 is r trau		Mary Lee Thompson		1	•			n Burnie, M		
ē,	of Heal		20a. Method of Disposition	20b.		sition (Name of natory or other)		Date ember 27	20c. Location - City of		
Ē	Page nent c ant: If ary or		1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ematory	_ 1500	2006	Catonsvill	e, Maryland	
baltimore,	permit. Departr Importe eny inje		21. Signature of Funeral Service License	e e	K 4	Name and Ad irkley- 21 Crai	dress of Facility Ruddick F n Hwy., S	uneral Ho .E., Geli	ome, P.A. n Burnie, M	D 21061	
	Dhusisian		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)								
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conse	equence of):	C OKE.	and prov	Thing e	Por .	dy	
ı		Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):						
Ď,	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a conse	equence of);				·		
09/g	cate be physici the bu	dical									
O. Box 6	The law requires that the death certific at has been signed by the attending proage 2 should be deteched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3[Ectopic pregna Other (specify			23d. Date of de Month	elivery Day Year	
٦.	es thet thighed by be detec	by Ph	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying cause	given in Part I.	23e. Did t	obacco use contribute	to the cause of death?	
g	w require been sig should b							10	Yes 2 □ No 31XE	bably 4 Unknown	
Kecc	The law resete has be	Completed				-			ormed? death?	utopsy findings available completion of cause of s	
ıta	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?					eath (Check only	one)		
on of v	Attending Physician: nr death. ector: After this certification by the funeral director.	မ	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. li	Other: 4 Nursing		dence 6 Other (Sp how injury occurred	ecify)	
Division of Vital Records,	or Attencater death Director:	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st cify)			28f. Location (City or To	Street and Number or F wn, State)	Rural Route Number,	
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medicai C		sician: To the best of my kiner: On the basis of examinand manner stated.							
	within To the	Me	29b. Signature and title of certifier				ense number		29d. Date signed (Mor	nth, Day, Year)	
)			173 / Nu	CM		C	3993	0	December 2	7, 2996	
	5		30. Name and address oberson who co				ster, Mar	yland 21	619		
	St Regist	ate trar	The second second second second	32. Aegistrar's Sig	nature	Market 2	_,	•			

06-09768	
Eddie Lonon, J	r. *

	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No. 2 1 1 5	4122					
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tim Month Day Year 4.7	ne of Death 14 hrs					
	4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2700 West Lafayette Avenue 4c. County of Death Baltimore						
Funeral Director	5. Social Security Number 217-70-2294 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace Foreign Months Days Hours Min. 01-25-1958 8. Party 1	(State or					
any	Tob. County Tob. County	Inside City Limits					
*	I MT I I DATI'I MADE'	Yes 2 No					
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2700 E. LAFAYETTE AVENUE 21216 U.S.A.						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be netified at once To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Inc. White, etc.						
s after d	Widowed 4 Divorced in test sive feet in test siv						
2 hours "natum		<u></u>					
5-0036 ed within 72 hour tygiene of the than "natu the Medical Exar Completed	12 th ROOFER PRIVATE 17. Festher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)						
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica							
D 212 should be and Ment 7 is mart ratic eve	19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C						
e, MD 1 and 2 sho Health and item 27 is r traumati	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town,	State					
Baltimore, permit. Pages I an Department of Hee Important: If iten injury or other ir	Woodlawn Cemetery 12-30-06 Baltimore, I	MD					
Balt permit. Depart Import injury	22. Name and Address of Facility Tay 101's Fulleral Hollie 1722 N. Capitol St. NW Wash. DC						
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	proximate Interval tween Onset and					
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Mixed drug intoxication (methadone and codeine) Due to (or as a consequence of):	Death					
-e	Sequentially list conditions, b. Due to (or as a consequence of):						
red Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
50, te be executed sysician and third - transit							
68760, certificate be nding physicis se as the buris sian/Medi		Year					
of Vital Records, P.O. Box 6876 ling Physician: The law requires that the death certificat. After this certificate has been signed by the attending phytheral director, page 2 should be detached for use as the on: To Be Completed by Physician/IM.	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (Specify)						
Boy he death he death y the att	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the ca	ause of death?					
P.O es that the strange of the stran	1 Yes 2 No 3 Probably	4 Unknown					
Division of Vital Records, P.O. tal or attending Physician: The law requires that the stater death are after death rail Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach entification: To Be Completed by P	24a Was an 24b. Were autopsy performed? death?	findings available etion of cause of					
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n of Ving Phy	27 Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred						
Division o tital or Attending ars after death ral Director: Aft lled in by the fun ertification:	Pending Investigation Suicide Suicide Suicide Suicide Suicide Pending Investigation of the Place of Injury - At home, farm, street, factory, office building, etc. Pending Investigation Street and Number or Rural Roor Town, State) 2700 W. Lafay	oute Number, City					
Divisior Spital or Attend hours after detail neral Director: filled in by the Certificatie		ette Ave.					
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detache. Medical Certification: To Be Completed by PP		se(s)					
F. S. S. S. S. S. S. S. S. S. S. S. S. S.		ay, Year)					
	30. Name and address of person who completed cause of death (Item 23a)						
	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
State Registra							
DHMH 17 Rev 1/2001	ORIGINAL ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Joseph Benard Lovett Jr. 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bel AIV Air Healtha Rehab Center Hartord 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **1**€ M 2 🗆 F Months Days Min. Hours 220-20-4124 12, Apr. Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford Maryland Belcamp 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4418 Greenwich Ct. 21017 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Styles 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes & No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Benard Lovett Sr. Rosalie Elizabeth Woodland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ada Lovett / Spouse 4418 Greenwich Ct., Belcamp, MD 21017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial /2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 1. Signa ir of Funers Function cent Dulaney Valley Mem 12-27-06 Timonium, Maryland 22. Name and Address of Facility McComas Funeral Home, P. A. 21. Signa 23a. Fartí. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a State

Director

Be Completed by Funeral

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or iter

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Department of important: If any injury or once.

Baltimore, Maryland 21215-0036

Box 68760.

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Examiner Physician/Medical Completed by Be Certification: To

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After

hours after death

within 24 hours a

completely

o the Hospital or Attending

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

2

1 Tes

27. Mann of Death

Natural

2 Accident

4 Homicide

(Chack only

3 Suicide

29a. Certifier

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

24a. Was an autopsy performed?

1 Yes 2 10 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 1 HO 1 🗌 Yes

23e. Did tobacco use contribute to the cause of death?

26. Place of Death (Check only one) 4 Jursing Home 5 Residence 6 Other (Specify)

Other: 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifier

5 Pending investigation

6 Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

se of death (Item 23a) (Type Print)

State Registrar

31. Date filed (Month, Day, Year) 2006

Manue

30. Name and address of person who completed



MP

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <u> Hans Werner Luethy</u> December 21, 2006 6:07 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) District 8. Date of Birth (Month, Day, Year) 1**∑**M 2□ F Months Days Hours 578-50-9304 June 2, 1940 of Columbia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3171 Hidden Ridge Terrace 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Manager Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hans Reinhard Luethy Gertrude (unk) Goertz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian E. Luethy / Wife 3171 Hidden Ridge Terrace, Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 12-22-06 Towson, Maryland 21. Signature of Funeral Service Licensee McComas Funerally Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final a ARTERIOSCLERUTIC CARDIDVASCULAR disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Funeral

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

e filed within 72 hours after al Hygiene. other than "natural", or ite

Pages 1 and 2 sment of Health an permit. Pages 1 and 3 Department of Health Important: If item 27 I any Injury or other tra once.

peen page 2 : certificate after death

Completed by Physician/Medical

Be

Certification: To

Medical

State Registrar

Hans M800400417 Vital Records, P.O. Box 68760

1 Yes 2 No 9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural

29b. Signature and title of certifier

4 ☐ Homicide

29a. Certifier

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

anhan MUD

2006

determined

29c. License number D25027

BEL ALR

AVE

29d. Date signed (Month, Day, Year) DECEMBER 21 2006

21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. ABHYANKAR NORTH

31. Date filed (Month, Day, Year)

DEC 2

32 Registrar's Signature

within 24 hours a

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #26 per Phy g862 12/2**C/Ortificant**e of Death 1. Decedent's Name (Eirst, Middle, Last) 2. Date of Death Day Month Year **Physician** 2006 0620 /Medical December 17 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ST AGNES HOSPITAL BALTIMORE If Under Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1**∑**MM 2 □ F 75 Director 30 1930 NORTH CAROLINA 229-30-5888 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any liury or other traumatic event, the Medical Examiner must he provided once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ¥XYes 2 No Director MARYLAND BALTIMORE N/A 10g, Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A. 21229 103 B ATHOL GATE LN Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**XX**No Specify. Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) APEX FUEL CO 12yrs 2vrs OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EFFIE MUSE AARON MUSE ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 103 B. Athol Gate Ln, Baltimore, Maryland 21229 Truevine H. Muse/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-22-06 LANSDOWNE, MARYLAND ZION CEMETERY re of Funeral Service Licen 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Do not enter the mode of dying, such as cardiac or respiratory arrest, 3a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsetjand Death Immediate Cause (Final disease or condition resulting in death) 1a C **Physician** lar 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be execute physician and sthe burial-trans Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death the detached 9☐Unknown n signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 3 Probably 1 TYes 2 No page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ★o 24a. Was an autopsy 1□ Yes 2 NO 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one, Be Other: 4 Nursing Home - 5. Nursing Home - 6 Other (Specify) ၉ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of De th 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director; Aft completely filled in by the fun 1 Tes 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and his of certifier 29c. License number 29d. Date signed (Month, Day, Year) MA and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name 200

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear **Physician** 5:37 pm 25 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPIT HUENUE Birthplace (State or Foreign Country) If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 X M 2 ☐ F Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number "natural", or Items 23a or edical Examiner must be Denning 21212 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify. Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) a 12th 00 K 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden_Surname) Pages 1 and 2 should be 1 nent of Health and Mental moure FELL ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Rd. Baeto, md. 21212 3 WIFE Benninghaus A. moore 61 enora Department of Health Important: If Item 27 any Injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Randallstown 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 30 06 permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 270 Fred HILTON Gan, P. march Funeral Home Belto, md. 21229 23a. Partit Einley the disease, or complications that caused the death. Do not enter the mile of dying, such as cardiac or respiratory arrest, shock, in leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat C se (Final disease of ndition resulting in death) Physician MYUCARDIAL wznes /Medical Due to (or as a consequence of): Examiner YPERTENSION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed CURUNARY attending physician and for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RECURRENT 1 Yes 2 No 3 Probably 4 Donknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No or Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After it completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and fittle of certifier 29d. Date signed (Month, Day, Year) December 25, 2006 00051865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITM BALTIMORE MI MARLES AGN25 CURTIG

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 451 2006 BARBRA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HARFORD UPPERILYSAFEAKE ITA 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 K F Director PG01 42816 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23e or 28e-f ehow idical Examinar must be multified at 1 ☐ Yes 2 No Director BURYRAP BALLIMORE 24,42501 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U-5.A 9108 3808 Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2∰ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 € Divorced BLAC Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry th and Mental Hygiene.
7 is marked other than "natur traumetic event, the Wadical 15. Decedent's Education (Specify onty highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HORRMAK 13705 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES A . HAINES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health of Health WILLAW HIS HILAMSIMUM LAWRENTS J 20c. Location - C y or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) permit. Pages:
Department of H
Important: If Ite
any injury or ot 29 Burial 2 ☐ Cremation 3 ☐ Removal from State DARLINGTO 4 ☐ Donation 5 ☐ Other (Specify) 21. S vna u e of Funeral Servi > License 22. Name and Address of Facility HABLALAGO ENAULTURION CONTRACTOR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on the suse on each line. Approximate Interval Between Onset and Death soleratio Cardio Vingela disente Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Cause (Cleans or inju-that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medlcal IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Wunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 7 No 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide determined 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

All Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) BEL AIR Md 1614 CHURCH 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State	of Marylan		artment of tificate of			ental Hy	giene	00	s. 1	1123	3
3,	Physici /Medio	al	Decedent's Name (First, Midd ROBERT 4a. Facility Name (If not institution)	MCC	ALL		45 City Taylor		I	2. Date of De Month DELEMB	Day	1 20	ear 06	3. Time of De	ath M
	Examin Funeral	er	JOHNS HOPKINS 5. Social Security Number	BAYVIEW 6. Sex			4b. City, Town, BA If Under 1 Yea Months Days	Himok	E	8. Date of Bi		County of		ice (State or Fo	oreign
The same	Director No.		216-10-0171 Usual Residence of Decedent 10a. State 10b. County	1 ∑ M 2 ☐ F		39 Yrs. y, Town or Lo		Tiodis	-	July 2	9 , 191	17 N	Mary.		imits
	ith the Mary or 28a-f eh	Director	Maryland Balti		I	Edgemere 101. Zip Code					10g. Citi	zen of Wha		1 □ Yes 2 X y?	JNo □
9	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other then "natural", or itema 23a or 28a-f ehow other traumatic event. The Madical Examiner must be notified at	Funeral Director	7222 Ligman Ave	12. Was Dec Armed F	cedent Ever in U. orces? 2 No		21 Was Decedent of f Yes, specify Cu 1 □ Yes 2 X No		igin? (Spec n, Puerto P	cify Yes or Ne Rican, etc.)	0-		America White, et	tc.	
21215-0036	within 72 hours ene. then "natural", ne Madical Exa	Completed by		Year or lint's Education ost grade completed,	Year or Dates:		lent's Usual Occupation kind of work done during most of workin DO NOT use retired)		ng	16b. Kir	Specify: nd of Busir	Whit ness/Indu			
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Baltimore,	t. Page rtrant o rtent: if		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3) 21. Signature of Funeral Service	Specify)	0	temetery, crer Lawn	sition (Name of natory or other pl Cemeter	У	Decen	2006	Duno	dalk, M	Mary]		
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Division of Vital Records,	ng Phys fter this ineral dii	atlon: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	28a. Date	Inpatient 2 Department 2 npatient	ER/Outpatier 28b. Time of Injury	28c. Inj	ther: 4 🗆 Nu	ırsıng Hom	ne 5 Res	idence (
Divis	To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: Al completely filled in by the fu	i Certification;	4 Hornicide	mined 288. Place	ding, etc. (Specif	y)	eet, factory, office		i i	City or To	iwn, State,)		Route Number	,
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)	10		30. Name and address of person				Print)	5-00						,2006	
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		1 - State Registrar	State of Man		artment of			giene 0 0	6 41234	
		Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death	
Physicia		Janet Amelia Mang	er				Decembe	er 22, 20	006 6:20 P M	
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Dea	th	4c. County o	Death	
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Funeral		5. Social Security Number 6. Sec		In yrs. last birthday	If Under 1 Yea Months Day		8. Date of Birl	y, Year, 1930	9. Birthplace (State or Foreign Country) Maryland	
Director		212-20-6433	IM 200 F 76	Yrs.			Aug. 1	4, 1930	Maryland	
and w		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limits	
Mary	ō	Maryland Baltimor	e	Catonsvi	.11e				1 ☐ Yes 2 🛣 No	
r 28a	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	nat Country?	
h with	O E	719 Maiden Choice	Ln., RGT 10	03	21228	}		United S	States	
deet	Funeral		12. Was Decedent Eve Armed Forces?		Was Decedent of	Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No	- 14. Race	- American Indian, White, etc.	
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n 72	Completed	15. Decedent's Edu (Specify only highest grad		(Give	edent's Usual Occ e kind of work don DO NOT use reti	e during most of wo	orking	16b. Kind of Bus	iness/industry	
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ld be lental rked	To B	Howard E. Manger	-			Margare	et Rodger	rs		
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and 2 and 2 selth a		Howard Carl Mange				r., Balt	imore, M	21228		
of He		20a. Method of Disposition 1 ☐ Burial 2 【②**Cremation 3 ☐ F	temoval from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other p	lace)	Date	20c. Location - C	ity or Town, State	
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permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylai permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylai Dependent of Health and Mandal Hygiens. Dependent of Health and Sas or 28a-1 ehow eny injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licens		290 F	unerai Ad	tome for Ca	terling-	Ashton-Scle, Inc.,	hwab-Witzke	
405 a		CIKA		1290 1	630 Edmo	ndson Ave	e., Cator	nsville,	MD 21228 Approximate	
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ding Pl		27. Manner of Death 1.☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	/ear) 28b. Time (Injury	of 28c. In	jury at lork?	28d. Describe	how injury occurre	d	
or Attendi	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (r - At home, larm, s (Specify)		Yes 2 No	28f. Location (City or To	n (Street and Number or Rural Route Number, Town, State)		
To the Hospital or Attending Physician: The law requires tha within 24 hours after death. To the Funeral Director: After this cartificate has been signed completely filled in by the funeral director, page 2 should be de	edical Ce	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of r ner: On the basis of ex and manner state	xamination and/or i	th occurred at the	time, date and place y opinion, death occ	ce, and due to the curred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)	
To the Within To the	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed	(Month, Day, Year)	
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		30. Name and address of person who c	ompleted cause of dear	th (Item 23a) (Type	, Print)			1		
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Sta Registr		31. Date liled (Month, Day, Year)	32. Registrar's	s Signatur9	parti		(

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	ledic amine		4a. Facility Name (If not institution, g 2652 Schult	ive street and number) Place					Location o	of Death		44	c. County Char	of Death		
Fune Direc			251-58-2859	Sex 7. Ag 12XM 2□F		last birthday) 57 Yrs.	If Under 1 Months	Days	If Under a	24 Hrs. Min.	8. Date of B (Month, I 1 0 – 28	inth Day, Year	39	9. Birth Cou S	place (State ontry)	or Foreign
Maryland f show	IN D NI	jo.	Usuel Residence of Decedent 10a. State 10b. County Char	les	10c. Cit	y, Town or Lo	waldo	rf							10d. Inside C	ity Limits
with the I	II De notil	Funeral Director	10e. Street and Number 2652 Schult	Place	l		10f. Zip (^{Code} 206	01			10g. C	itizen of V		ntry?	
Deficiencies, Mid yield A. I. I. 2000 Dependency in the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-1 show	Examinar mis		11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? IN Yes 2 □ I If Yes, Give Year or Dates:	Everin U 19!	50	Was Decede			gin? (Spe i, Puerto f	cify Yes or N Rican, etc.)	10-	Blac	k, White	can Indian, etc. Casia	n
d within 72 ho giene. or then "natur	Ine Medical	Completed by	15. Decedent's (Specify only highest of Elementary Secondary (0-12)		5+)	(Give	dent's Usual kind of work DO NOT use mobil	k doné a e retired,	luring mosl)		ng		Kind of Bu		•	
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mit. Pages 1 partment of H portant: if ite	Jury or off		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Donation 5 ☐ Other (Special Control of Con	city)	Ana	Place of Disposementery, cres	Regi	str		2/2	ate 5/06 lor's	Gl	en B	urn	own, State ie, M	D
permit. Departr Importe	eny in		21. Signature of Funeral Service Lic	chul II	-	1	7.22 N	Addres	s of Facilit	ol s	st. N	W Wa	ash.	DC	2000	2
To the Hospital or Attending Physicien: The law requires that the death certificate be executed Within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and Personal Directors.	ical ner	dical Examiner	23a. Pan11. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as C. Due to (or as Due to (or as	a conseq a conseq	uence of):	A. C	£.	J. Such as	W W	G,	arrest,	16		Approxima Interval Be Onset and	tween Death
To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funarsi Director: After this certificate has been signed by the attending ph	ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3	⊒Ectopic pre ☐ Other (spe						23d. Dat Moi	e of deliv	•	Year
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ital or Att	led in by t	Certification;	3 Suicide 6 Could not determine	building, et	c. (Specif	(y)					City or T	own, Sta	te)		al Route Nur	nber,
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ant	1		39. Name and address of person wh	2 H. W.	ATK	FEN)	Print)	0,	WA	71	Don	۴,	MI	15	060	3
Re	Sta gistra		31. Date filed (Month, Day, Year) DEC 2 7 2006	32. Registr	ars Signa	Jack.	9									

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	arylan		rtment of H		Mental Hy	giene Rag. No	2005	41236
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of De			3. Time of Death
	/Medic		James Franklin M	26					Decem	her.	25,2006	4155ам
	Examir	ner	4a. Facility Name (If not institution, give s	11	1-1		4b. City, Town, o	r Location of Dea	ith	40	County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age		ast birthday)	If Under 1 Year	If Under 24 Hr		rth	9. Birth	place (State or Foreign
	Director		213 32-1303	M 2□F	71	Yrs.	Months Days	Hours Mir	May 17	, 19	35 Virg	intry) inia
	and we		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation					10d. Inside City Limits
	Mary -f ehc	ţŏ	Maryland Baltimore		Ba	ltimor	e					1 ☐ Yes 2X No
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	ath wi	rai	2006 Summit Avenu				21237			UŞ		
0	item Item	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	 Was Decedent E Armed Forces? 1 Type 2 Tub 			as Decedent of H Yes, specify Cuba	fispanic Origin? (an, Mexican, Pue	Specify Yes or No into Rican, etc.)	0-	 Race - American Black, White 	
v∧e. 5-0036	ours after death with the Manylan ret', or iteme 23a or 28a-f ehow Examinar must be notified at		3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		1	☐ Yes 21X No	Specify:			Specify:	hite
5.0	within 72 hours after death with the Maryland sne sne then "naturet", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		(Give k	ent's Usual Occup	during most of w	orking	16b. 8	(ind of Business/Ir	
2121	swithin 72 ho plene. r then "natur the Medical	mpi	Etementary/Secondary (0-12)	College (1-4or 5	+)	lite. D	O NOT use retired	d)				
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/an	2 should be and Mental is marked o	To B	James Leonard Mo	rrison				Sally	Bell Cro	ouse		
150M Maryland	2 should and Men is marke		19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailing	Address (Street	and Number or F	Rural Route Numb	er. City	or Town, State, Zi	p Code)
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NOrr altimore,	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	l l		ition (Name of atory or other place	I I			290	
alti 🦳	그 문문을		21. Signature of Funeral Service License	e /	Hal		emorial Name and Add <u>re</u>		-29-06 Home, P.2	Abe	rdeen, M	aryland
<u> </u>	Depermine Depermine Control on the C		Stesley all	Kuch		1	occomas f 317 Coke	uneral R sbury Ro	nome, P.A Dad, Abir	A. nado:	n. Marvl	and 21009
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused e cause on each lin	the death							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Stapl		ureu	s set	515				Onset and Death
	/Medical Examiner			Due to (orlas a			(
		Jer	Securities is conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Neuty Due to (or as a	a co sequ	ence of):		74/				
	be executed sicien and burial-transit	Examiner	that initiated events	acute	W		actis 1	eulle	Mia			
8760,	be exercien a	E	resulting in death) Last	Due to (or as a	a consequ	ence :						
687	ficate physics the l	edical	d									
Вох	ath certific ittending p or use as:	M/M	IF FEMALE: 23b. Was decedent pregnant	Bc. It yes, outcome of	of pregna						23d. Date of deliv	rery
B	or Attending Physician: The law requires that the death certificate be executed fiter death. Director: After this certificate hes been signed by the attending physicien and in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			Ectopic pregnancy Other (specify)	/			Month	Day Year
Division of Vital Records, P.O.	hat the od by t Jetach	Phy	9 ☐ Unknown Part II. Other significant conditions con-		it not resu	tting in the un	derlying cause gr	ren in Part I	23e Did	tobacco	use contabute to I	the cause of death?
ds,	tw requires that s been signed b should be det	d by	COPD. Hyperte	nsion. F	705	rate	Cance	V-			No 3 Pro	
9	s beer shou	jete							24a. Was	an	24b. Were auto	opsy tindings available ompletion of cause of
æ	The lav	mo							auto perfe	psy ormed? 2 ☑ No	death?	
/ita	ystclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner?						eath (Check only	$-\!$		
o d	Physic this o	7	1 ☐ Yes 2 No	ospital: 1 X Inpatier 28a. Di te of Injur		R/Outpatient 28b. Time of		4 🗀 Nursing	Home 5 Resi		6 ☐Other (Speci	fy)
lon	ith. :: After s funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Intury	28c. Injur Wor M 1	k? Yes 2∐No	200. Describe	III WOII	ily occurred	
× ×	or Attendiate after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Intu	iry - At ho	me, tarm, stre	et, factory, office		28t. Location (City or To	Street a	nd Number or Run	al Route Number,
	oital o urs aft oral Di											
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	er: On the best of and manner sta	examinat	viedge, death ion and/or invi	occurred at the tire estigation, in my o	me, date and place pinion, death occ	e, and due to the curred at the time,	cause(s date an	i) and manner as s d place, and due t	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	_			29c. Licens	e number		29d. Da	ite signed (Month,	Day, Year)
			CARKONTU	rachines	المالك	2 Mi	Do	06313	r6 T	De	cember	25,2006
/	/ (30. Name and address of person who con	mpleted cause of de	eath (Item	23а) (Туре, Р	rint)			0	11 010	a a a
	<i>y</i>		31. Date filed (Month, Day, Year)	Wachine 32. Registra	me r	e M.r	1,9000 F	ranklin,	Ja. Drive	, Da	HO, MU.	d1237
1	Sta Registi		DEC 2. 7. 2	10.7	_ wighter	10 A	and the		1			

		1	For State Registrar	State of Mary	land / Depa	artment rtificate	of He	alth a eath		R	eg. Nó	06	41237
			I. Decedent's Name (First, Middle, Last)							Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic	al		e McNulty		45 035 3		tion of		DEC 2	23, 200 4c. County		6:45a
	Examin		la. Facility Name (If not institution, give s	treet and number)				ocation of				rrol]	L
			Continuum Care 5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under	1 Year	svill Under 2	24 Hrs. 8.	Date of Birth (Month, Day	1		plece (State or Foreign ntry)
	Funeral Director		131-01-1949	M 2DXF	89 Yrs.	Months	Days	Hours	Min.	UG 31		New	York
	0	\ ⊢	Usuel Residence of Decedent	100	c. City, Town or L	ocation						T	10d. Inside City Limits
	ehow	<u>.</u>	New York Queens	100	5. Oly, 10m1 01 L	Breez	v Po	int					1 ☐ Yes 2 📉 No
	28a-f	O	10e. Street and Number			10f. Zip					10g. Citizen of		intry?
	with with		2 Gotham Walk				1	1697				USA	
1	me 23	Funeral		12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Deced	lent of His	panic Orig	gin? (Specif i, Puerto Ric	y Yes or No- can, etc.)	14. Rad Bla	ce - Amer ck, White	ican Indian, , etc.
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Important: if item 27 ie marked other then "natural; or iteme 23a or 28a-f ehow important: if item 27 ie marked other then "natural; or iteme 23a or 28a-f ehow princy or other traumatic event, the Medical Examinat must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☼ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes	77	Specify:			Specia	fy:	White
5	2 hou	ted	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Giv	dent's Usua e kind of wo	rk done di	urıng mosi	t of working		16b. Kind of B	Business/I	ndustry
7	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	inist:	se retired)			1	C1e	rica	1
Z	tygier her th		12 17. Father's Name (First, Middle, Last)		Adii	THITSU					Maiden Suma		
and	ntai h	Be	Charles Shar	nnon					Brio	dget M	cEnroy		
ج	should Me Me mark mark	٢	19a. Informant's Name/Relationship (T)								r, City or Town		
S	alth al		Regina Bodnar - n	iece	and the same of th	Tang		od Dr		-	ille, M		
e,	of He of He rothe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ F	Removal from State	20b. Place of Disp cemetery, cri	ematory or o	other place	9)	Dat		20c. Location		
Ĕ	Page ment: fi ant: fi ury o		4 ☐ Donation 5 ☐ Other (Specify)		Calvary	Cemet	ery		2/27/				w York
Baltimore, Maryland 21215-0036	permit. Depertimport eny inj		21. Signature of Funeral Service Licens Paux Hught 2 23a. Part1. Enter the disease, or comp	ferbert	P	aight 0. B	Funi ox 19	ra1 95_Sy	Home (& Char 11e, M	e1 D 21784	+ (41	0-795-1400) Approximate Interval Between
	Physician /Medical Examiner properties and properties and properties and properties are properties are properties and properties are properties and properties are properties and properties are properties and properties are properties and properties are properties and properties are properties and properties are properties and properties are properties and properties are properties and properties are properties and properties are properties and properties are properties and properties are properties and properties are properties and properties are properties are properties are properties and properties are properties are properties are properties are properties are properties and properties are properties are properties are properties are properties are properties are properties are properties are properties are properties are properties are properties are properties are properties are properties are properties are properties are properties are properti	cal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond	onsequence of):								
687	tificate ig phy: as the												
.O. Box	ne death cer the ettendir shed for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 □Ectopic p 5 □ Other (s						ate of de	livery Day Year
<u> </u>	ires that the signed by I be detact	全	Part II. Other significant conditions of	ontributing to death but r	not resulting in the	underlying	cause giv	en in Part	l.		tobacco use co Yes 2 ☐ No		o the cause of death? robably 4 🗖 Onknown
of Vital Records,	e law requir has been si je 2 should	Completed									s an 24t opsy ormed? 2 BNo	prior to death?	utopsy findings available completion of cause of
a		ပိ	25. Was case referred to medical					26. Plac	e of Death	1 ☐ Yes (Check only			
Ξ	Physician: this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpat	ient 3 🗆 D	OA Oth				idence 6 🗆 C	other (Spe	ecify)
on of	Jing Phy J. After this funeral o	Ilon: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time Injur		28c. Injur Wor 1 🗆	yat k? Yes 2[8d. Describe	how injury occ	urred	
Division	To the Hoepital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury building, etc.	(Specify)					City or To	wn, State)		lural Route Number,
	Moepiti 24 hours Funere etely fille	dicai	29a. Certiffer 1 Cartifying Ph (Check only 2 Medical Exar	ysician: To the best of ninar: On the basis of e and manner state	xamination and/or	ath occurre r investigation	d at the ti	me, date a opinion, de	and place, a eath occurre	and due to the	, date and plac	e, and du	6 (0 life 02030(3)
	To the Within 2 To the comple	₩.	29b. Signature and title of certifier	^				e numbe			_		th, Day, Year)
	40		30, Name and address of person who	combined cause of dea	ath (Item 23a) (Ty	pe, Print)	D006	0560	0		DECEM	BER	23,2006 HE, MD
	1,		PANKAT KHETE	RPAL 201	BACK	RIV	ER I	NEC	K RD	#100	1, BAL	-TIM?	OKE, MD
	S	tate	31. Date filed (Month, Day Year)	2006 32. Registrar	's Signature	Bran	No D						

DHMH 17 Rev 1/2001

PM

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,

Year

Registra 's Signature

06-09805
Frederica Morrison

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

redefica Morrisor	1	- For State Critificate of Department of He equistrar Certificate of De			1. No. 200	
Physician Medical Examine	/	I. Decedent's Name (First, Middle, Last) Fredricka Momison		2. Date of Death Month December		3. Time of Death - 1945 hrs
		da. Facility Name (if not institution, give street and number) 4b. C	ity, Town, or Location of Death		4c. County of Death	Λ
Funeral		5. Social Security Number 6. Sex Z. Age (In yrs. last birthday)	Under 1 Year If Under 24Hrs	- 4	1-	hplace (State or
Director	ļ	77-92-2010 1 M 2 YF Yrs.	onths Days Hours Min.	Aug. 1,	1965 Foreign	untry) Ma
v any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	D.11:			10d. Inside City Limits
Maryland 28a-f show			Battimore	10	g. Citizen of What Cou	1 Yes 2 No
n with the Maryland ns 23a or 28a-f sho	Director	1012 Mosher St. Apt. B	21217		US.	A
be filed within 72 hours after death with the Maryland mal Hygiene riked other than "natural", or items 23a or 28a-f shem, the Medical Examiner must be notified at once Do Computed by Elimonal Disorbor	Funeral		cedent of Hispanic Origin? (Sp pecify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
hours after d	ᇍ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	2 No specify:	york done	Specify: 616 Specify: 616 Specify: 616	adustry
6 172 hour an "natt cal Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	f working life. DO NOT use retir		Labor Re	-
21215-0036 Juld be filed within 72 Mantal Hygiene marked other than ' e event, the Medical	E	17. Father's Nagne (First, Middle, Last)	18.Mother's Name	(First, Middle, M		
D 21215 should be file and Mental H, 7 is marked o	8	FRA KOSS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	Eloise			
e, MD 2 1 and 2 shoul Health and In item 27 is n r traumatic	≗[Reineshia Jones-daughter 5203	ress (Street and Number or F W. Actt Al		Timore, M	ryland 1
or Hez		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other place.		Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I a Department of He Important: If ite injury or other ti	1	4 Donation 5 Other Specify:	and Address of Faility Jan	Ker Fuse	thome!	4. 4221
Physician	÷	3512 23a. Part I. Enter the sease, or complications that caused the death. Do not enter the me	ode of dying, such as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval
/Medical Examiner		failure List only one cause on each line. Mecrotizing acute pneumonia	complicated by na	rcotic use	<u> </u>	Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, b.				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c				
cuted nd ransit	_	events resulting in death) Last Due to (or as a consequence of):				
760, icate be executed physician and the burial - transit	Medical		1/11/07TT		Toologic	
Sox 6876 leath certificat e attending ph for use as the	/sician/N	3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal de		ncy	23d. Date of delivery	Day Year
Box 68	£L	1 Yes 2 No 9 V Unknown 9 Unknown	(Specify)			
P. P. C. Street	2	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.		pacco use contribute to 2 ✓ No 3 Prot	
ords, w requir as been s s should!	Completed			24a. Was a autops	y prior to d	topsy findings available completion of cause of
Vital Rec ysician: The la his certificate h director, page		25. Was case referred to medical	26.Place of Death (Check	perform 1 Yes 2		s 2 No
Vita	e Be	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3	DOA Other Nursin	g Home 5 F	Residence 6 Other	
On of chading Phending Phent After the funeral		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe h	ow injury occurred	
livision Lor Attendante death Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	ctory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Ruate)	ral Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: Completely filled in by the	a Ce	4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a	at the time, date and place, and	due to the cause	(s) and manner as state	ed.
To the Ho within 24 P	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in an analysis and manner stated, 29b. Signature and title of certifier	n my opinion, death occurred a	t the time, date a	nd place, and due to th	
15		/	O.C.M.E.		December 24, 20	
127	Ì	30. Name and a dr ss of p, son who completed cause of death (Item 23a) Mary G. Apple MD. Deputy Chief Medical Examiner 111 Pe	enn Street, Baltimore, M	ID 21201		
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Registro		OEC 2 7 2006 ORIGINAL	رغايد			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Physician Month 2:13 PM MAC December 23,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hopkins Himore, der 1 Year | If Under Johns Hospita 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 11/27/1916 Months Davs Hours 1 M 2 □ F Yrs. 90 Director 218-22-2773 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD 1√∑Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 319 East Lanvale Street 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify. Specify: African American 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laundry worker Regal Laundry 4th permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eddie Woods Alice Woods 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles McNeil / Son 1022 Cooks Lane; Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State f Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 12/29/2006 Randallstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AOF tic LOURS /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28h Time of 27. Magner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar PARIZAD TORAB 31. Date filed (Month, Day, Year)

crohi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins 32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

06-09770	
Joseph Myerberg	

State of Maryland / Department of Health and Mental Hygiene 2006 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day December 22, 2006 Medical Examiner Η. JOSEPH MYERBERG 1657 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Owings Mills 20 Hartley Circle #427 **Baltimore County** 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** Months Days Hours Directo 04/17/1980 213-02-4268 1 X M 2 26 Yrs Country MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 1II 10d Inside City Limits 28a-f show 1 Yes 2 X No BALTIMORE MD OWINGS MILLS death with the Maryland Director 10e Street and Number 10f. Zip Code 10g Citizen of What Country lat fied 20 HARTLEY CIRCLE #427 21117 USA items 23a Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Armed Forces? White, etc. Married Yes 2 X No hours after If Yes, Give Year 1 Yes 2 X No specify WHITE Specify "natural". 2 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b. Kind of Business/Industry Completed ss I and 2 should be filed within 72 ho of Health and Mental Hygiene If item 27 is marked other than "na her traumatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 STUDENT EDUCATION 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) HENRY MYERBERG JUDY SOLOMON Be or other traumatic event, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HENRY MYERBERG / FATHER 20 HARTLEY CIRCLE #427 - OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place! 1 X Burial 2 Cremation 3 Removal from State portant: ANSHE EMUNAH (AITZ CHAMM) 12/24/2D06 HALETHORPE, MD Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Mixed drup intoxication (methadone and romethazine) Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and sician/Medical X UNPENDED ending physician use as the burial -AMENDED #23a.27.28a-f perME, g863, 1/10/07 TT The law requires that the death certificate be P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death the attending Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed death? certificate Yes 2 V No No 25. Was case referred to medica To the Hospital or Attending Physician: 26.Place of Death (Check only one) Be examiner? Other₄ Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene After this 2 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work' Manner of Death 28d. Describe how injury occurred 1 Natural within 24 hours after death

To the Funeral Director:
completely filled in by the f 5 Pending Yes 2 X No Fnd 12/22/2006 unknown unknown 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 20 Harley Circle #427 28e. Place of Injury - At home, farm, street, factory, office building, etc. X Could not be 3 Suicide determined (Specify) other-scene Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbei 29d Date signed (Month, Day, Year) O.C.M.E. December 23, 2006 Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registra

ORIGINAL

			State Registrar		partment of Health and ertificate of Death		ene 0 0 6	41242
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	Examin		4a. Facility Name (If not institution, give street as		4b. City, Town, or Location of De	ath	4c. County of Death	
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	th with th	ai Dire	10e. Street and Number 300 Salony Drive Apt	. 302	10f. Zip Code 21136	10g	. Citizen of What Cou SA	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28e-f ehow any Injury or other treumatic event, the Medical Enature is intentified at ODGE.	by Funeral Director	1 ☐ Never Married 2 🕅 Married 1 📆	Decedent Ever in U.S. ed Forces? Yes 2 No WWII s, Give or Dates:	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu □ Yes 2 ▼ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White, Specify: Whit	etc.
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Baltimore, Maryland 21215-0036	uld be filed v Aental Hygie rked other t tlc event, tr	To Be Co	17. Father's Name (First, Middle, Last) Simon Navarre	Sa	18. Mother's N	lame (First, Middle, Ma e Guidry	iden Sumame)	
, Mary	and 2 sho eith and N 27 is ma		19a. Informant's Name/Relationship (Type, Prin Cynthia M. Navarre (s		Salony Dr., Apt.			
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8760,	Physician and /Medical Examiner	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	that caused the death. Do not on each line. ULDOMARULE to (or as a consequence of): te to (or as a consequence of):	enter the mode of dying, such as card	iac or respiratory arrest		Approximate Interval Between Onset and Death
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			For State Registrar	State of Ma	ryland / D	epartmei Certifica	nt of Hea te of De	alth and Meath		giene Reg. No.	006	41244
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	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: Affer this certificete ha completely filled in by the funeral director, pege	edical	29a. Certifier 15 Certifying Physical (Check only one) 2 Medical Examination	ician: To the best of er: On the basis of and manner state	examination and	, death occurre d/or investigation	d at the time, on, in my opini	date and place, ion, death occur	and due to the red at the time,	cause(s) ar date and p	nd manner as s lace, and due t	tated. o the cause(s)
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			30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type Print)	Mr	Mand (Jenera) t	f. crol	ial
		ate	31. Date filed (Month, Day, Year)	1	r's Signature		* * \$000	10-0103				
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** David C. Ressin 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Hospital Center Roseda 1 Under 1 Year If Un Baltimore 8. Date of Birth (Month, Pay, Tune 11, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1915 Maryland 212-01-6325 91 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, ILA Medical Examinar must be notified at MD Baltimore Parkville 1 Tyes 2 MNo Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. 21234 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married SpecifWhite Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry essin, David Elementary/Secondary (0-12) 12 College (1-4or 5+) Bethlehem Steel N/Ā General Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be f Mental I Nathan Ressin Dora Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health at Important: If item 27 is any injury or other trau Elaine Lawton- Daughter 2713 Hunting Ridge Ct. Baldwin, MD 21013 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Oaklawn Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/27/2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name vans Puteral Chapel & CRemation Services-Parkville 8800 Harford Rd. Farkville, MD 21234 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure 2 weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner sicien and burial-transit resulting in death) Last Due to (or as a consequence of) ed by the attending physicien detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours atter death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2: autopsy performed? Yes 2 No 2 No 1 Yes I or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 14 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 29b. Signature and title of certifier D0060453 December 22 2006 124are 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Anastasios Salianis MD, 9000 Franklin Square Drive, Baltimore MD, 21237 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 2 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 11:18AM Douglas Stuart Rees December 21 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner gnes Sount 1more HOSPITA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**™**M 2□F Aug. 28, 1950 Director 546-84-9844 56 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1∏Yes 2□No r 28a-f sh notified Funeral Director Maryland Baltimore with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be a 2414 James Street 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 2[XNo 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Principal</u> Education Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finance and Mental H Be David Iswald Rees Regina Nesbitt ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua Rees Son 110 Doncaster Road; Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/23/2006 Catonsville, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc., 1630 Edmondson Avenue, Catonsville, MD 21228 21. Signature o Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ulminant disease or condition resulting in death) don /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner physician and s the burial-transi resulting in death) Last 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending F s after death. Il Director: After d in by the funera Division 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 S. Caton Avenue, Baltimore , MD21229

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month,

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32. Registrar's Signature 🛵

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	niner	4a. Facility Name (If not institution	give street and nu	mber)		4b. City,	Town, or	Location	of Death		4c. C	ounty of	Death		
		Charlestown Ca	re Center	•			nsvi					Ltimo	re		
Funer Directo		5. Social Security Number 128–09–2888	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 97	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Jul.	6,190	9 I	Birthplac Country taly	ce (State or	Foreign
and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							100	I. Inside City	y Limits
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** RUBY 12:41 am BONNIE December 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Oct. 21, 1 THE JOHNS HOPKINS HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 64 Usual Residence of Decedent 1942 Maryland Director 10b. County 10a. State 10c. City, Town or Location rai', or itama 23a or 28e-f ahow Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death 2217 Stockton Road <u> 21085</u> USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours efter 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify ğ 3 Widowed 4 Divorced natural White at Hygiene. I other than "nature ivent, the Medical E Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ith and Mental F 27 is marked of traumatic avail ဂ Ralph (unk) Orndoff Cathryn (nmn) Barncard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health a important: If Item 27 is any injury or other traisons. David Stanley Ruby / Husband 2217 Stockton Road, Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. 12-27-06 Timonium, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Home, P.A. Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician 2 DAYS /Medical Due to (or as a consequence of): Examiner D. ACUTE MYELOGENOUS LEUKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 YEARS Due to (or as a consequence of) Examiner or Attanding Physician: The lew requires that the death certificate be executed GRAFT VERSUS HOST DISEASE 6 MONTHS Due to (or as a consequence of): physicien are s the burial-t Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificete 20 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No f Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural effer death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours e To the Funeral [To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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Registrar

State

(marke)

MARYLAND

HOSPITAL, 600 NORTH WOLFE STREET BALTIMORE, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DAVID MATURE, M.O. THE JOHNS HOPKINS

2006

31. Date filed (Month, Day, Year)

DEC 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 9:30A Keed December 2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner OAK CREST CARE CENTER PARKVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. Norths Days Hours Min. 8. Date of Birth (Month, Day, Year) 2/19/1917 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🏋 F Yrs. 89 MARYLAND Director 218-24-2364 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 1 ☐ Yes 2 🛣 No Director MD BALTIMORE PARKVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ıral", or items 23a or I Exaπiner must be 8800 WALTHER BLVD. APT. 3509 21234 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nant of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or iten Iry or other traumatic event, the Medical Examiner 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) lementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN HOWARD FETTY MARGARET PRICE BRYAN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5708 N. CHARLES STREET BALTIMORE, MD GREGORY LEE REED/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/27/2006 METRO CREMATORY, INC. CATONSVILLE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Liosn Tlea Wan 8521 LOCH RAVEN BLVD. TOWSON, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Due to (or as a nsequence of): Physician /Medical Examiner gartic critical Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) the 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ischemic cordiomy opathy drabetes heart 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an intermittent autopsy performe 2 No 1□ Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending investigation after death.

I Director: A:
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 61785 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar X on MD

31. Date filed (Month Pay, Year)

*680*0

37 Registrar's Signature

Walther

Boulevard.

Parhulle MD 21234

	150	-	For Amend Item	State of Maryland / D 4c per dr., G862,	epartment of 1 12/27/06dhb Certificate of			ne No.2006	41250
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) Murles Ro	che			Dec 1	Day Year 2 2006	3. Time of Death 5.500M
	Examin		4a. Facility Name (If not institution, give st	reet and number)	11	MORE M	0	4c. County of Death	& Shoter
	Funeral Director		5. Social Security Number 6. Sex 11 1 1 1	7. Age (In yrs. last birth	4444 4 444		Date of Birth (Month, Day, Ye /16/1934	ar) 9. Birthp Cour	lace (State or Foreign laryland
	Maryland -t ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arur	ndel Glen E				1	0d. Inside City Limits 1 ☐ Yes 2√ No
	ith the	Olrec	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	ntry?
	death w	neral	205 Wellham Avenue	N. W. 2. Was Decedent Ever in U.S. Armed Forces?	21061 13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No- can, etc.)	USA 14. Race - Americ Black, White,	
9036	ours after rel', or Ite	d by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ▓ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	1 □ Yes 2 No	Specify:		Specify: Wh	ite
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Item 27 le marked other than "naturel; or Iteme 23a or 28a-t ehow other traumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of working d)	16b	. Kind of Business/In	dustry
d 21	Hygier Hygier other th		17. Father's Name (First, Middle, Last)	0 /	Welder	18. Mother's Name (F		Manufactur den Sumame)	ing
Maryland	should be filed withir nd Mental Hygiene. marked other then imatic event, the Ma	To Be	George Roche			Catherin	e Slaugh	nter	
Many	2 should in and Men 7 le marke raumatic		19a. Informant's Name/Relationship (Typ		Mailing Address (Street				
	0 0		Peggy Rhodes / Daug 20a. Method of Disposition X Burial 2 Cremation 3 Re	20b. Place of)51 Parksles Disposition (Name of v. crematory or other place			E, Maryland . Location - City or To	
Baltimore,	rt. Partmentmant:		4 Donation 5 Other (Specify) 21. Jignatur of Funeral Service License	Glen H	Haven Cemete	ery 12/15/			
Ba	Depa Impo eny I		Michael (Sonider		ens Avenue,			
	Physician // / / / / / / / / / / / / / / / / /	ıl Examiner	23a. Part1. Enfer the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	P S \ S pt):	g, 300 100 00 00 00 00 00 00 00 00 00 00 00			Approximate Interval Between Onset and Death
.O. Box 68760,	death certific e attending p id for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	у		23d. Date of deliv Month	ery Day Year
s, D	luires that n signed b ild be deta	þ	Part II. Dther significant conditions con	tributing to death but not resulting in	the underlying cause giv	ven in Part I.		co use contribute to t 2 ☐ No 3 ☐ Prof	_/
of Vital Record	i: The law requires that the icete has been signed by th	Completed					24a. Was an autopsy performed	prior to co death?	opsy findings available impletion of cause of
Vit.	Physicien: T this certificet ral director, pa	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Mnpatient 2 ☐ ER/Ou	tpatient 3 DOA Oth	26. Place of Death (ner: 4 ☐ Nursing Home		e 6 ⊡Other (Specia	fy)
	After Arter		27. Manger of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. T	ime of 28c. Injury Wo		d. Describe how		,,
Division	- 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28	f. Location (Stree City or Town, S	t and Number or Run Itate)	al Route Number,
	To the Hospitel of within 24 hours after To the Funerel D completely filled in	edical (sician: To the best of my knowledge ner: On the basis of examination and and manner stated.					
	withir To th	Ř	29b. Signature and title of certifier	marls, m	29c. Licens	se number	29d.	Date signed (Month,	Day, Year) 12006
	(D)		30. Name and addr. of person who	1 \	Type, Print) Sh	Paul St	ret !	Bultimore	MOZ
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Por Mo				

DHMH 17 Rev 1/2001

ORIGINAL

6-09723 Nitchell Jerome F	Roth	man Please Type or Print in State of Marylan							- 11051
	1	For State eqistrar		ate of D				g. No. 2006	5 41251
Physicia Vledical Examin	n/ 1	. Decedent's Name (First, Middle,Last) MITCHELL	J.		ROTHMA	N	2. Date of Death Month December		3 Time of Death 2007 hrs
	4	la. Facility Name (if not institution, give street and number Carroll Hospital Center	per)		City, Town, or L Vestminster		h	4c. County of Death	
Funeral Director	į	5. Social Security Number 6. Sex 7. 1X M 2 F	Age (In yrs. last bir	_	f Under 1 Year Months Days	If Under 24Hi Hours Mi	-	n(MM/DD/YYYY) 9. Bir Foreiç / 1 9 4 5 Co	
Á.		Jsual Residence of Decedent Oa, State 10b. County	10c. City, Town				00/14/	15.10	10d. Inside City Limits
daryland 28a-f show any 1 at once.		MD CARROLL		WESTM	IINSTER		· ·		1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once.	Dire	10e. Street and Number 1255 STONE ROAD		1	0f. Zip Code	21158	10	g, Citizen of What Cou	USA
r death with	Funeral	11. Marital Status 1 Never Married 2 X Married 12. Was Decer	dent Ever in U.S. ces?		ecedent of Hisp specify Cuban,		Specify Yes or No- o Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
		Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade	/IETNAM	. Decedent's	es 2 X No Usual Occupation	n (Give kind of		Specify: 16b. Kind of Business/	WHITE
, MD 21215-0036 and 2 should be filed within 72 hours after teath and Mental Hygiene ten 27 is marked other than "natural" traumatic event, the Medical Examine	Completed by	Elementary/Secondary (0-12) College (1-4	or 5+)	SALES	of working life.	DO NOT use re	mired)	COMPUTER	.S
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medica	e Con	17. Father's Name (First, Middle, Last) MAX	ROT	HMAN	1	8.Mother's Nan	ne (First, Middle, M	faiden Surname)	LEVIN
D 212 should be and Ment 7 is mark 1 atic ever	ToB	19a Informant's Name/Relationship (Type, Print) DARLA ROTHMAN / WIFE	19	9b. Mailing A	,	and Number or	Rural Route Num	ber, City or Town, State	
Baltimore, MD permit Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumati	-	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from	20b. Place crema	of Disposition atory or other	n (Name of cem place)	etery,	Date	20c. Location - City or	Town, State
timent or trant:	-	4 Donation 5 Other Specify: 21. Synattre of Funeral Service Lice See	HAR S		EMETERY ne and Address		/24/2006		IILLS, MD
Bal permi Depa Impo	Į.	Mychall Mus	el	89	00 RFIS	TERSTO	N ROAD .	INSON & BRO - PIKESVILL	E. MD 21208
Physician /Medical		23a. Part I. Enter the disease, or complications that cal failure. List only one cause on each line.	sed the death. Do r				or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a c		ic Garaio	asoular Bloc				
	iner	if any, leading to immediate cause. Enter Underlying Cause	onsequence of):						
e executed cian and rial - transit	I Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a c	onsequence of):						
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Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be ras after death. al Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the burn		1 Live bir past 12 months?	nt at time of death	2 Fetal	death 3 [Ectopic preg	nancy	23d. Date of deliver	y Day Year
). Bo the dea by the a	Phys	1 Yes 2 No 9 Unknown 9 Unknow Part II. Other significant conditions contributing to		ing in the und	erlying cause g	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
s, P.C	ed by						-	2 No 3 Pro	
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach.	Completed				_	-	24a, Was autop perfor 1 ✓ Yes	sy prior to med? death?	utopsy findings available completion of cause of
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of Vit Physici er this c	ဦ	examiner? 1 V Yes 2 No Hospital: 1 In In 28a. Date of 28a. Date of 28a.		Outpatient :	J DON	Other Nurs		Residence 6 Other	ert:
Sion C attending death. ctor: Aft y the fun	ation	1 V Natural 5 Pending 2 Accident Investigation (Month,	Day,Year)		1 Y	es 2 No			
Divis ital or At urs after d	Certification:	3 Suicide 6 Could not be determined (Specify)	of Injury - At home,	farm, street,	factory, office bi	uilding, etc.	28f. Location (S or Town, S		ural Route Number, City
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Physician: To the best one) 2 Medical Examiner: On the basis of	examination and/or	leath occurre r investigation	d at the time, da	te and place, a death occurre	nd due to the caus d at the time, date	e(s) and manner as sta and place, and due to t	ted he cause(s)
To To	Med	29b. Signature and title of certifier	ared .		29c. License			29d Date signed (Me	
16		30. Name and address of person who completed cause					201		
,	ate	Carol Allan, MD Assistant Medical E	strar's Signature	reiii ol	reet, Baltimo				
Regist	trar	DEO G I COL		W.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Rovine December 11 a 23 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltmore No-thwest Randallstown Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State of CounCANADA 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 0873071919 1 ☐ M 2 🕅 F 053-10-4010 87 Director Usual Residence of Decedent with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 TYes 2 X No PIKESVILLE Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be no 21208 USA 725 MT. WILSON LANE #417 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🕅 No þ Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOFFMAN BERGER KATE SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 103 NORTH VILLAGE LANE - CHADDS FORD, PA 19317 HARVEY ROVINE / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State MIKRO KODESH BETH ISRAEL 12/24/2006 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Lett M. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stoph **Physician** aureus week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 ☐ Other (specify) I ☐ Yes 2 Ø No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? malnutrition 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed congestion 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 \ No 1□ Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 Tes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 35844 MO 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown 5400 old Court Road Koggen Suite 108 21133

DHMH 17 Rev 1/2001

State

Registrar

DEC 2

31. Date filed (Month,

32. Registrar's Signature

A Maria

06-Kei

-09797 ith Robinson		Please Type or Print in Black Indelible Ink. State of Maryland / Department of He				gible.	
		1- For State Certificate of De			Re	eg. No. 20	06 4125
Physicia edical Exami					 Date of Dear Month December 	nth Day Year r 23, 2006	3 Time of Death 1432 hrs
			ity, Town, oi altimore (Location of Death		4c. County of De	eath
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Jnder 1 Yea	ar If Under 24Hrs.	8. Date of Bir	rth(MM/DD/YYYY) 9.	
Director		213-90-5561 1X M 2 F 40 Yrs. MG	onths Day	rs Hours Min.	01/24/1	1966	reign Country) MD
iny		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
and show a	'n	, MD	Balt	imore			1 X Yes 2 No
Maryli r 28a-f ed at o	Director	10e. Street and Number 10f. 4014 Ge1ston Drive	Zip Code	01000		0g. Citizen of What C	-
with the s 23a o			cedent of Hi	21229 spanic Origin? (Spe		- 14. Race - An	oA nerican Indian, 8lack,
death v or item must b	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, sp	ecify Cuba	n, Mexican, Puerto I	Rican, etc.)	White, etc	
rs after ural", o	百	Wildowed 4 Divorced in res, diverses 1 Test of the rest of the second of	2 X No		ork done	SpecifyAfri	can American
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department: If litem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add				mber, City or Town, St	
and 2 steath a traum		20a Method of Disposition 20b. Place of Disposition ((Name of ce		Date	e, Maryland 20c. Location - City	
more		1 Burial 2 Cremation 3 Removal from State crematory or other plants and the plants of		01/04	/2007	Baltimore,	Maryland
Baltimor permit. Pages I Department of I Important: If	1 1	21. Signature of Funeral Service Licensee 22. Name				al Home, P.A	
Physician	0.00	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo		_		ore, Maryland	21217 Approximate Interval
/Medical Examiner	2 0	failure. List only one cause on each line. Immediate Cause (Final disease a. Acute myocardial infarction	ŕ				Between Onset and Death
ZAAIIIIIGI		or condition resulting in death) Due to (or as a consequence of): b. HYpertensive atherosclerotic	cardi	ovascular d	isaasa		
	ner		, cardi	ovalxariar a			
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
executed an and al - transit	cal E						
- 0) .2.5	Medic	#23a-b.PIT.27.perME.	g864 2	/2/07_TT		23d. Date of deliv	very
ertil ding	Physician/Medi	23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal department Pregnant at time of death 5 Other (Ectopic pregnar	псу	Month	Day Year
30x death he atte	hysic	1 Yes 2 No 9 Unknown 9 Unknown					
Records, P.O. Bo The law requires that the de cate has been signed by the page 2 should be detached f	by P		lying cause	given in Part I.			to the cause of death? Probably 4 Unknown
ords, w requires s been sig should be	eted				24a. Was		autopsy findings available to completion of cause of
Division of Vital Records, rate death as Attending Physician: The law requires and redeath and Directors. After this certificate has been seled in by the funeral director, page 2 should the	Completed					ormed? death	1?
L	Be C	25. Was case referred to medical examiner?		e of Death (Check o			
Division of Vital Hospital or Attending Physician: 24 hours after death Funeral Director: After this certif rely filled in by the funeral director,	. To	1 V Yes 2 No Impatient 2 V Envoupatient 3	DOA 28c. Inji		Home 5 28d. Describe	Residence 6 Of thow injury occurred	ther.
ion c tending eath tor: Af	ation	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1	Yes 2 No			
Division pital or Attencours after death eral Director:	Certification:	3 Suicide 6 Could not be determined (Specify)	ctory, office	building, etc.	28f. Location (or Town, S		Rural Route Number, City
Divisior Hospital or Attend 124 hours after death e Funeral Director:			at the time, o	late and place, and	due to the caus	se(s) and manner as s	stated
To the P within 2. To the F	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	n my opinio	n, death occurred at		and place, and due to	o the cause(s)
. > - 0	Ž	29b Signature and title of certifier	29c. Licen O.C	se number .M.E.		29d. Date signed (December 24,	
9		30. Name and address of person who completed cause of death (Item 23a)				1	
- /	5 W	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn St	treet, Bal	timore, MD 212	201		
S Regis	tate trar	and the second s	E)				
		The state of the s	-				

ORIĞINAL

06-09825 Joseph M. Sullivan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 41254

		- For State egistrar				Certifica	ate of	f Dea	ath	_		Re	g. No.			
Physiciar Medical Examin	1/	1. Decedent's Name (First, Middl JOSEPH MICHAEL		LLIVAN								Date of Dear Month December	Day	Year		3. Time of Death 1528 hrs
	ľ	 Facility Name (if not institution 108 Lyndale Avenue 	n, give s	street and nur	nber)				, Town, or Lo tingham	ocation of	Death		- 1	County of altimore		nty
Funeral		5. Social Security Number	6. Sex	T	7. Age (Ir	yrs. last birt	hday)	If Ur	nder 1 Year	If Under	24Hrs.	8. Date of Bir	th(MM/D	D/YYYY)		nplace (State or
Director	١	218-26-7286	1 X N	1 2 F	76		Yrs		nths Days	Hours	Min.	March	15,1	L930	Foreign Cou	^{ntry)} Maryland
*		Usual Residence of Decedent			Iao	0 T-										10d Inside City Limits
Maryland 28a-f show any d at once.	.	Maryland Balti	more	9	100	c. City, Town	or Local		altimo	ore C	ount	٧				1 Yes 2 No
arylar 8a-f s		10e. Street and Number							Zip Code				0g. Citiz	en of Wha	at Count	try?
the M		108 Lyndale Ave	nue						2123	36			USA	١		
th with	Funeral	11. Marital Status 1 Never Married 2 M		12. Was Dece Armed Fo		er in U.S.			edent of Hispa ecify Cuban, I			cify Yes or No can, etc.)	- /	4. Race - White,		an Indian, Black,
iter dea			- 1	1 X Yes Yes, Give Year	1948	[№] 1952	1	Yes	2 X No	specify:				Specify:	Wt	nite
ours a	<u></u>	15. Decedent's Education (Spe	cify only	highest grad	e comple	ted) 16a.	Deceder	nt's Usu	al Occupatio	n (Give ki	ind of wo	rk done		nd of Bus		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera Propertment of Health and Mental Hygiera "natural", or items 23a or 28a-f sho injury or other transmatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) 12 yrs.		College (1-N/A	4 or 5+)		•		Office		ise retiret	1)		ltim lice		City
-00; d with giene ther t	탉	17. Father's Name (First, Middle	Last)						18	B. Mother's	Name (F	irst, Middle, I			- 501	
215 be file tral Hy ked o	Be	Michael Joseph		llivan						Fre	ida	Wozny				
21. ould b d Men s mar iic eve	2	19a. Informant's Name/Relations	hip (Typ	pe, Print)		19	b. Mailin	g Addre	ess (Street	and Numb	er or Ru	ral Route Nur	nber, Cit	y or Town	State,	Zip Code)
MD dd 2 sh lith an m 27 i		<u>Patricia M. Sul</u>	liva	an (Wi	fe)				dale A			<u>ltimor</u> Date				Sown, State
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmatic event, the Medican		20a Method of Disposition 1 X X Burial 2 Cremation	3	Removal fro	m State	cremat	ory or of	ther pla	ce)	200						
lime Pagrant Tant:		4 Donation 5 Other S				Garde			aith L		12~2	9-2006	Be	iltim	ore,	, Maryland
Ball permit Depar Impon		21. Signature of Funeral Service	0	1							Hom	e 7401	. Be	lair	Rd .F	Balto,Md.21236
Physician	+	23a. Part I. Enter the disease, or	complic	cations that ca	used the	death. Do no	ot enter	the mod	de of dying, s	uch as ca	rdiac or r	espiratory arr	est, sho	ck, or hea	rt	Approximate Interval Between Onset and
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease			scler	otic ca	rdiov	ascu	ılar dis	ease						Death
}	-	or condition resulting in death)	D	ue to (or as a	consequ	ence of):										
Mary and the second sec	힐	Sequentially list conditions, if any, leading to immediate		ue to (or as a	consequ	ence of):										
	틽	cause. Enter Underlying Cause (Disease or injury that initiated	Ü	ue to (or as a	consequ	ence of):										7.0
760, ficate be executed g physician and the burial - transit	Physician/Medical Examiner	events resulting in death) Last	_ d				_					_				
), be exe sician sician urial -	힗	XUNPENDED		\$232,P1	I,27,	perME,	g864,	, 2/8	3/07 TT							
8760 rificate b	ِ اِ	IF FEMALE: 23b. Was decedent pregnant in t	he	23c. If yes, o		of pregnancy		etal dea	ath 3	Ectopic	pregnano	cv		. Date of o Month		ay Year
Box 68 death certifine he attending of for use as	ici ai	past 12 months?				6 - 4 41-	"	ther (S			p g	,				
Box ne death of the attented for us	lys Lys	1 Yes 2 No 9 Un		9 Unkno						in Des	215	220 Didt	abassa i	ico contrib	outo to t	he cause of death?
rds, P.O. Box 6 requires that the death cer been signed by the attendi	و م	Part II. Other significant condi Large B Cell I		-			-								_	ably 4 🗸 Unknown
dS, squires	ted		-JP	,								24a. Was	an			opsy findings available
cords law requi	Completed	exposure											rmed?	d	eath?	ompletion of cause of
tal Rec		25. Was case referred to medical	. T			_			26 Place o	of Death (Check on	1 Yes	2 No) 1	✓ Yes	s 2 No
Vital ysician: his certif	a	examiner?	_	ospital: 1	npatient	2 ER/C	utpatier	nt 3		Mhor -		Home 5	Resider	nce 6	Other:	Scene
of Vir ing Physic After this	٤	27. Manner of Death	1111	28a. Date (Month	of Injury	28b.	Time of	Injury	28c. Injury	at Work?	2	8d. Describe	how inju	гу оссите	:d	
on: A	흹		ding estigation		, Day, I can	'			1 Y	es 2	No					
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death To the Funeral Director: After this certificate has been signed by th completely filled in by the funeral director, page 2 should be detache	Certification:	3 Suicide 6 Cou	ild not be	e 28e. Plac	e of Injur	/ - At home, f	arm, stre	eet, fact	ory, office bu	uilding, etc	. 2	8f. Location (or Town, \$		nd Numbe	r or Rur	al Route Number, City
Di Hospital 24 hours a Funeral		4 Homicide 29a Certifier		n: To the bes	t of my k	nowledge de	ath acci	irred at	the time, dat	e and plac	ce and d	ue to the caus	se(s) and	d manner	as state	ed.
To the Hos within 24 h To the Fur completely	Medical	(Check only	aminer:	On the basis	of examin											
To CO	Me	29b. Signature and title of certifi		and manner s	n .s			T	29c. License	number			29d [ate signe	d (Mon	oth, Day, Year)
		Allina N	la.	sell.	M	5.			O.C.N	1.E.			Dec	ember :	25, 20	06
	Ì	30. Name and address of perso					444	<u>-</u>	Ctroat D	altina	. NAD O	1201	1			
(1)	أب	Melissa Brassell, MD		sistant Me	73			-	Street, Ba	aiumore	, IVIU Z	1201				
Sta Regist	ate rar	31. Date filed (Month Per Year	7 21	006	Supplied S	Signature	1	224	E)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Louise D. Sanders December 24, 2006 **Physician** 5:30 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Augsburg Lutheran Home Gwynn Oak Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 23, 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 F 190-01-7574 Director 1915 Harwick, PA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits or items 23a or 28a-f show uniner must be notified at Baltimore MD Baltimore 1 ☐ Yes 2 No Director 10f. Zip Code 21207 10e Street and Number 6811 Campfield Rd. 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 12 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWhite Completed by 3 Widowed 4 □ Divorced Year or Dates: of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At HOme N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Lerch Anna Koller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline S. Babcock-Daughter 4101 Dee Jay Dr. Ellicott City, MD 21042 20a. Method of Disposition
1 ☐ Burial 2 MCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages Department of Important: If its any Injury or o Evans Funeral Chapel/Belair 12/27/06 Forest Hill, MD 4 □ Ponation 5 □ Other (Specify) 21. Signature of Funeral Service Lioense ²² Peaceful Alternatives Funeral & Cremation Center 2325 York Rd. Timonium, MD 21093 ent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Im diate Cause (Final Physician bre est Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe o 2 No 3 Probably Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 autopsy perform certificate 2000 1∐ Yes or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ ₩6 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 5 Pending investigation 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31 Date filed (Month, Day, Year)

Kaymond Miller

Transment Mille

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25 Main Street

Sinte

32. Registrar's Signature

29c. License number

Rustestown

29d. Date signed (Month, Day, Year)

12/26/06

21136

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{\text{Day}}{2}4$, $2\overset{\text{Year}}{0}6$ **Physician** 4:58 A M December David S. Swayne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) **Funeral** Hours 1⊠M 2□F 212-42-5711 1937 Director 69 Aug. 6, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Catonsville Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 1223 White Mills Road United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Purdue Norman L. Swayne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1223 White Mills Rd., Catonsville, MD 21228 Catherine L. Swayne / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 12-27-2006 Metro Crematory Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of FacilitySterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc., M01290 1630 Edmondson Ave., Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, heart failu Immediate use (Final disease or condition resulting in death) **Physician** 16ara 0 /Medical Due to (as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an this certificate has page 2 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician:

filed within 72 hours after death with the Maryland

completely filled in by the funeral within 24 hours after death. To the Funeral Director: After To the Hospital

State Registrar 29a. Certifier

29b. Signature and title of certifier

6701 6 BMC 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

N. Charles St.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 40 AM WAVTZ 23 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Baltimore Baltimore PMML Gorge MD Date of Birth (Month, Day, Year) Year If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Min. Months 1 M 2 F 63 Yrs. Hours Maryland Director 216409674 Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10d. Inside City Limits r 28a-f show notified at **Funeral Director** 1 ☐ Yes 2 ☑ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? artment of Health and Mental Hygiene. ortant: If them 27 Is marked other than "natural", or items 23a or in Jury or other traumatic event, the Medical Examiner must be not pury or other traumatic event, the Medical Examiner must be not pure the statement of the Medical Examiner must be not pure the statement of the Medical Examiner must be not pure the statement of the statemen 12. Was Dicedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedenl's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Carpenter Home Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell W. Schwartzbeck Hilda Mae Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5617 Prince George St., Gwynn Oak, MD 21207 Wanda G. Schwartzbeck/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or 5 ☐ Other (Specify) 4 Donation Crest Lawn Memorial 12-27-06 Marriottsville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc., 21. Signature of Funeral Servic Licensee 1630 Edmondson Ave., Catonsville, MD 21228 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest pnly one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. Li Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offi Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical attending ph for use as t IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant all time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown page 2 should Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe certificate 2 **☑** No 25. Was case referred to Hospital or Attending Physician: funeral director, medica 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 🗆 Yes 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural Injury after death. 1 □ Yes 2 □ No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only the 29b. Signature and title of certifier 29c. License number 30. Name and address of percon who completed cause of death (Item 23a) (Type, Print) 0

Registrar

State

31. Date filed (Month, Day,

Year)

DEC

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dav Year **Physician** Paul David Smith 20, 2006 4:15 Å December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Air 502 King Arthur Court Harford Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Davs Hours 1 ☑ M 2 ☐ F Director 430-98-4233 53 Apr. 28, 1953 Arkansas Usual Residence of Decedent 10c, City, Town or Location 10d Inside City Limits r 28a-f show notified at 10a State 10h Count 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 502 King Arthur Court 21015 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify. þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) $5\pm$ Physician U.S. Army marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental i Important: If item 27 is marked o any Injury or other traumatic eve Robert Lee Smith Bernita Fave Triebsch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Grace Smith/Wife 502 King Arthur Court, Bel Air, MD 21015 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Doher (Specify) Arlington National 1-22-07 Arlington, Virginia 22. Name and Address of Facility
McComas Funeral Home, P. A. 21. Sign ur of Funer 50 W. Broadway, Bel Air, Maryland 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** montus Kena /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed signed by the attending physician and abe detached for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy Year Month in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ξ. 1 es 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? 1 Yes 2 No death? 1 🗌 Yes certificate 2 ☐ No Division or Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58303

21/

31. Date filed (Month, Day, Year) State DEC 2 Registrar



2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMIN J. CHAMBS, W 6565 N. Chanks St Tows N M 21204 TORAL!

			For State Registrar	State of N	Maryland		artment of H				iene .g. No2 0 0 6	41260
	Physici	an	1. Decedent's Name (First, Middle	, Last)					2.	Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Gene Olin Sel 4a. Fecility Name (If not institution		ar)		4b. City, Town, or	Location		ecember	21, 2006 4c. County of Deat	6:55 P ^M
	Examin	er	Upper Chesape			r	Bel Ai		Or D'Outil		Harford	
7	Funeral		5. Social Security Number	6. Sex 7	Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under	Min. 8.	Date of Birth (Month, Day,	9. Birt	hplace (State or Foreign
×.	Director		212-70-5773 Usual Residence of Decedent	1 3 M 2	53	Yrs.					, 1953 New	
	Maryland		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	a-f eh	ctor	Maryland Harf	ord		Joppa:	towne					1 ☐ Yes 212 No
	with the a or 28e Lbe noti	Director	10e. Street and Number				10f. Zip Code			10	0g. Citizen of What Co	untry?
	daath v	Funerai	1021 Emmerick D	rive	nt Ever in U.S.	13	21085		rigin? (Specif	v Yes or No-	USA 14. Race - Ame	rican Indian
36	perrit. Pages 1 and 2 should be filed within 72 hours after daath with the Marylan Depirtment of Health and Mendal Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 ehow may injury or other traumatic event, its Medical Fearings must be rollified at any injury or other traumatic event, its Medical Fearings must be rollified at answer.	by Fun	Never Married 2 Marr 3 Widowed 4 Divorced	Armed Force	s?	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 2 No	Specify:		an, etc.)	Black, Whit	
	72 hou	ted	15. Deceden (Specify only higher	's Education		16a. Dece	dent's Usual Occup	ation	st of working	1	16b. Kind of Business/	
855 1215-0036	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-40	or 5+)	`life.	DO NOT use retired	dining mos	st or working			
2	Hygier Hygier ther th		12 17. Father's Name (First, Middle,	l ast)		Dis	abled	18 Moth	er's Name (F	First Middle N	Maiden Surname)	
and	ked o	To Be	Olin Wesley S						•		an Barnes	
altimore, Maryland	2 should be filed and Mental Hygin is marked other aumatic event, II		19a. Informant's Name/Relations			19b. Mailir	ng Address (Street				City or Town, State, 2	Zip Code)
∑	and 2 ealth a m 27 i		Genevieve Sellm	an/ Mother	-		the state of the s	Driv			ne, MD 210	
~ 0	ges 1 t of Hi if iten or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 Removal from Sta	te cer	metery, crei	sition (Name of matory or other place		Date		20c. Location - City or	
<u>Q ₽</u>	pernit. Pag Depirtment Important: I any injury c		4 □ Doylation 5 □ Other/(S	<i></i>	Hil		Service C		12-23		lowson, Mai	ryland
Bal	Deprit Deprit Import any in		Mark				McComas F	unera	al Home	e, P. A	A. don, Maryla	21000
			23a. Part. Enter the 1 sease, or shock, or heart failure. List	complications that caus	sed the death.	Do not ent	er the mode of dyin	g, such as	s cardiac or re	espiratory arre	ost,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	MET	ASTA	TIC	MELA	HONA	MA		1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseque	ence of):						10
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ence of):						
	cuted	Examiner	that initiated events	c								
Do.	ite be executed iysicien and ne burial-transit		resulting in death) Last	Due to (or	as a conseque	ence of):						
23	cate b physic the b	dica		d								
Box	death certificat ie attending phy ad for use as th	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		me of pregnand 2 Fetal of at time of dea	death 3	Ectopic pregnancy		710		23d. Date of del	ivery Day Year
=0	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		atti 5 [Other (specify)					
20	es that the igned by th be detache		Part II. Other significant condition				1	en in Part	l.	23e. Did tob	acco use contribute to	the cause of death?
35	w requires been sign should be	ted	Hypertensi	1	etes					1 ☐ Ye	s 20 No 3 □ Pr	obably 4 Unknown
Rec	The larate has	Completed by	CHRONIC K	ENAL INS	UFFIC	IENC	y			24a. Was an autopsy penform 1 ☐ Yes 2	y prior to ged? death?	itopsy findings available completion of cause of 2 No
a la	ysicien: Th is certificate director, pag	Be	25. Was case referred to medica examiner?	Hospital: V			Oth	05		Check on one	***	
75	Phys this ral di	. To	1 Yes 2 No 27. Manner of Death	28a. Date of li		P/Outpatier 28b. Time o		4 🗆 NI			nce 6 Other (Spe	cify)
∑. <u>5</u>	nding lath. r: After e funer	atior	1 Natural 5 Pendir 2 Accident investi	g (Month,	Day Year)	Injury	Wor	k? Yes 2 □			1-12	
Divis		Certification:	3 Suicide 6 Could 4 Homicide determ	ined 286. Place of	Injury - At hon etc. (Specify)		eet, factory, office		28f	Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,
Š	To the Hospital or Atti within 24 hours after de To the Funeral Direct completely filled in by ti	edicai C	29a. Certifier (Check only one) Certifyir 2 Medical	g Physician: To the be Examiner: On the basis and manner	s of examination	ledge, deat on and/or in	h occurred at the tin vestigation, in my o	ne, date ar pinion, dea	nd place, and ath occurred	d due to the ca at the time, da	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
	Vithir Vithir Comp	M	29b. Signature and title of certifie	in war	> W/K	გ	29c. Licens	o number	ĵ	19.6	ed. Date signed (Mont	
1	T		30. Name and address of person	who completed cause of	of death (Item :		Print)	1/ 1		1	5 .	22, 2006
		113	31. Date filed (Month, Day Year)	KMAN .	308 L	74	SS G W	4 5	- dopo u	2000	21040	
1	Sta Registr		31. Date filed (Month, Day, Yeal) DEC 2 7	2006	Se S.	Agos	ALL!					

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type Print) (Himore BIVD Westminster IND 211

29c. License number

D 23443

29d. Date signed (Month, Day, Year)

21157

12-26-00

wood

VAYWALA

29b. Signature and title of/certifier

DEC 2 7 2006

MAYAM 31. Date filed (Month, Day, Year)

			1 - For State Registrar Amend Item	State of Man 23a per d	yland / Depa r.,G862 i	artment of L 2127/06d dificate of	lealth and Death	i Mental Hyo	giene neg. No.2 0 0 1	6 41263
	Physici	an	1. Decedent's Name (First, Middle, Last)	11				2. Oate of Dea	ith Day Ye	3. Time of Death
	/Medic		Samuel Sil	berg				Dec.	11, 2006	7,42 AM
	Examir	er	4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of De	eath	4c. County of C	Death
			5. Social Security Number 6. Sex		In yrs. last birthday)	If Under 1 Year	If Under 24 F	PS 9 Date of Rief	Hon	Distribution (Charles
	Funeral Director			M 2□F	61 Yrs.	Months Days	Hours M			Birthplace (State or Foreign Country) Maryland
	72 hours after death with the Maryland Inatural; or Items 23s or 28e-f show Jisal Extractor ast be retilled at	tor	10a. State 10b. County Maryland Hov	vard	Oc. City, Town or Lo		Ilicott Ctiy			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	is after death with the Marylan , or Items 23a or 28e-f show	I Director	10e. Street and Number 3111-D Wheaton Way	, und	***	10f. Zip Code	21043		10g. Citizen of What	t Country?
	death ms 2	Funeral		12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - A	American fndian,
036	urs after al', or Ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: √		If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	an, Mexican, Pu Specify:	erto Rican, etc.)	Black, V Specify:	White, etc. White
21215-0036	C * (M)	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	during most of v	working	16b. Kind of Busine	ess/Industry Deliveries
	illed withii Hygiene. other than		17. Father's Name (First, Middle, Last)	2		(Courier	lama /First Afiddle	Africa Community	
Maryland	o d at D	To Be	unkn	own			18. Mothers h	lame (First, Middle,	unknown	
Mar	id 2 should and the and the shoul		19a. Informant's Name/Relationship (Type					Rural Route Numbe		te, Zip Code)
	s 1 and if Health Item 27 other to		Mrs. Patricia Perkins Silbe 20a. Method of Disposition		20b. Place of Dispo		1	Date Date	20c. Location - City	or Town, State
<u>E</u>	Pages nent of i ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	_	remation Se	1	12/15/2006	Sykesv	ville, Maryland
Baltimore,	permit. Pages Department of Important: If It any injury or o		21. Sign ture of Fuheral Service Livens	L mans		2. Name and Addre Slack	ss of Facility Funeral Ho	me, P.A.	. 0:: 145 044	240
			231. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	e death. Do not ent	er the mode of dyir	old Columb ng, such as card	oia Pike Ellicot iac or respiratory ari	t City, MD 210 rest,	Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final isease or condition resulting in death)	Aspro	tion	Aspira	tion 1	Pneumonia		Onset and Death 15-minufes
	Examiner		Sequentially list conditions	,	onsequence of):					
	be sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury	Due to (or as a c	consequence of):					
8760,	ate be executed hysician and the burial-transit	ical Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
O. Box 6	The law requires that the death certificate be executed the bas been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of particles of the second of the sec	Fetal death 3	Ectopic pregnanc	′		23d. Date of Month	delivery Day Year
S, D	res that igned b be deta	by	Part II. Other significant conditions con	tributing to death but n	not resulting in the u	nderlying cause giv	en in Part I.			e to the cause of death?
ord	w require been si should b	eted	19 pe Divotes	Mellitus 14	Typertens	iena		- 1 Y	es 2Latro 3L	Probably 4 Unknown
I Records,		Completed	Abriel Fibrillo	Periphere	(Ne.	reports.	7	24a. Was a autop: perfor	sy prior	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lo anitali		-104		eath Check on or	76	
0	두 두 등	5	1 Yes 2 No	lospital:			4 Nursing	Home 5 Resid		Specify)
lon	ding h. After fune	atlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time o	Wor	yat k? Yes 2∐No	28d. Oescribe h	ow injury occurred	
Division	or Attending after death. Director: After d in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, sti 'Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Number of n, State)	r Rural Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 12 Certifying Physical Check only 2 Medicel Examination	sicien: To the best of n ner: On the basis of ex and manner stated	camination and/or in	h occurred at the tir vestigation, in my o	ne, date and pla pinion, death or	ice, and due to the courred at the time, of	ause(s) and mannel late and place, and	r as stated. due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	7		29c. Licens	e number	2	29d. Date signed (M	onth, Day, Year)
)			1 Del	- p	70	1746	120	4	Dec. 1.	1, 2006
			30. Name and address of person who co	a A -	th (Item 23a) (Type,		10/5	John be		21044
•••	Sta Regist		31. Date filed (MDEC 2 2 2 200	26	Signature	and a	1	-13/6	. 1/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** RE /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** JOH NS BACTIM ORCE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) HUSPITAL Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 212-88-2013 Director 11/24/1961 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at MD 1 XYes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1123 North Gilmor Street 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify African American 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **FEMA** Federal Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Stith Jean Joyner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 LaTrobe Street; Baltimore, Maryland 21202 Jean Joyner / Mother 20a. Nethod of Disposition

11 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) Garrison Forest Cemetery 12/27/2006 Owings Mills, Maryland 21. Signature of Funeral Service Licensy 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MESENTERIC ISCHEMIA

Due to (or as a consequence of): Physician hours /Medical MIXED (ON WECTIVE TISSE OISEASE **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 1∐ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate the Hospital or Attending Physiclan: hin 24 hours after death. the Funeral Director: After this certifica mpletely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: Impatient 1 Tyes 2 NO Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANDRY, THE JOHNS HOPKINS HOSPITAL 600 HORTH WOLFESTREET, MARYLAND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DEC 2

			For State Ragistrar	State of M	laryland		artment of rtificate of		and Menta		ene . Na 2 0 0 6	41265
	-4		1. Decedent's Name (First, Middle, Las	')						te of Death		3. Time of Death
ı	Physici /Medic		SARAH ELIZABE	TH THORN	TON					onth cember	Day Year 21 2006	10:00a ^M
*	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of			4c. County of Dea	th
200		Section 1	LORIEN FRANKFORD	NURSING	CENTE	ER	BALT	IMORE			N/A	
	Funeral		Social Security Number 6. Se		ge (In yrs. I	ast birthday)	If Under 1 Year Months Days			te of Birth onth, Day, Y	9. Bir	thplace (State or Foreign
	Director		212-46-3241]M 2 X]F	62	2 Yrs.	Months Days	110010			1,1944	VIRGINIA
	p v		Usual Residence of Decedent 10a. State 10b. County		10c Cib	, Town or Lo	antina					Last to the control of
	sho	5	Tou. State		loc. Only	, TOWN OF LO	Gallori					10d. Inside City Limits 1 ☐ Yes 2X No
	vith the Maryland or 28e-f show	Director	MARYLAND BALTIMO	RE			MIDDLE	RIVER	}			
	Aily of a	ä	10e. Street and Number				10f. Zip Code			10g	. Citizen of What Co	ountry?
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	Reme Institut	in.	11. Marital Status	12. Was Deceden Armed Forces 1 ☐ Yes 200	?	5. 13.	Was Decedent of f Yes, specify Cu	Hispanic Original ban, Mexican	gin? (Specify Yo i, Puerto Rican,	es or No- etc.)	14. Race - Ame Black, Whit	
36	ours after death with el', or Reme 23a or Ezertiner n'est be	by	1XXVever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	MAO		1 ☐ Yes 2 🕱 No	Specify:			Specify: B	LACK
5-0036	i 72 hours after death with the Maryland "neturel", or Reme 23a or 28e-f ehow idical Examinar mast be notified at		15. Decedent's Ed			16a. Dece	dent's Usual Occu	ination		16	b. Kind of Business	
15	n n	Completed	(Specify only highest grad	ie completed)	F. ()	(Give	kind of work done DO NOT use retir	during most	t of working			dustry
2121	fited within Hygiene.	E	10th grade	College (1-4or	5+)	FAC	TORY WOR	KER			PRIVAT	Е
b	itled Hygie other	Bec	17. Father's Name (First, Middle, Last)						er's Name (First,	Middle, Ma		
<u>a</u>	Mental Mental arked o	To B	unknown					LOV	ELINE			
Maryland	\$ 5 E E		19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailir	ng Address (Stree			e Number, C	ity or Town, State,	Zip Code)
	1 and 2 Health a tem 27 le		Shirley C. Payne/	Cousin		709	Gladway	Rd., M	Middle R	liver,	Md., 212	20
re,	of Health Item 27		20a. Method of Disposition		0.0	lace of Dispo	sition (Name of natory or other pl	acel	Date	20	c. Location - City or	Town, State
E	Pages nent of I ant: If the arry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify		9		LLS MEMO	,	2-27-06		IDDLE RIV	ER, MARYLAND
Baltimore,	- EEF		21. Signature of Funeral Service Licens		1101	22	. Name and Addi	ess of Facilit	у			
ä	Department of the policy of th		May long	1							L HOME-HA ERDEEN, M	RFORD, P.A.
4			234 Part 1. Enter the disease, or comp	ications that cause	d the death							Approximate
	Physician		shock, or heart failure. List only	one cause on each	L'ola	C11-A	16					Interval Between Onset and Death
Š.	/Medical		disease or condition resulting in death)	a. Due to (or a	s alconsequ	Tence of):						
	Examiner					31.00 01).						
T.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	ence of):						
	ansit	Examiner	Cause (Disease or injury that initiated events	c								
ó	exec an an rial-tr		resulting in death) Last	Due to (or a	s a consequ	ence of):						
8760,	The law requires thet the death certificate be executed wie has been signed by the attending physicien and bage 2 should be deteched for use as the burial-transit	Physician/Medical	(d								
9	rtifica ng ph as th	Jed	IS ESTABLE.									
Вох	leath certifica attending ph d for use as th	an/	230. Was decedent pregpant	23c. If yes, outcom- 1 Live birth			Ectopic pregnan	ev.			23d. Date of de	·
	ed fo	SCI	in the past 12 months? 1 Yes 2 No	4☐Pregnant a			Other (specify)				Month	Day Year
P.0	that the de ned by the a deteched f	Phy.	9 Unknown	-							<u> </u>	
	es the igned be de	b	Part II. Other significant conditions co	ntributing to death	but not resu	ulting in the u	nderlying cause g	iven in Part I.	. 23	3e. Did tobac		the cause of death?
ord	w requires been sign should be	ted								1 🗌 Yes	2 €No 3 P	obably 4 Dunknown
Records,	has be	Completed							24	a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
<u> </u>	The ete h page	20							1[performe	d? death?	
/ita	sicien: Th certificete rector, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death (Chec	ck only one)		
of Vital	Physicien: this certifice ral director, I	ဥ	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat	ient 2 🗆 I	ER/Outpatier	t 3□ DOA O	ther: 4 Nu	rsing Home 5	Residenc	e 6 Other (Spe	city)
	ding P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury	W	ury at ork?	28d. D	escribe how	injury occurred	
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				M 1	Yes 2 1	No			
Division	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of Ir building, e	njury - At ho etc. <i>(Specif</i> y	me, farm, str /)	eet, factory, office)	28f. Lo	cation (Streety or Town, S	et and Number or Ri State)	ural Route Number,
	urs a urs a gral C	C										
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	ledicai	29a. Certifier + Certifying Phy (Check only one) 2 Medical Exam	iner: On the basis	of examinat	wledge, deatl tion and/or in	n occurred at the vestigation, in my	time, date an opinion, dea	d place, and du th occurred at th	e to the caus ne time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	the the mple	Med	29b. Signature and title of certifier	and manner s	tated.		29c Licer	ise number		104	Date signed (Most	h Day Yearl
	F 3 F 8		100000000000000000000000000000000000000					1272	7	290	Date signed (Mont	., Jay, redij
			MAIN				ע) י	110	/		a 122/00	
7) '		30. Name and address of person who o	empleted cause of	61		Print)	7 1 Dan	Derd	9 . 1	1001	279
	201		31. Date filed (Month, Day, Year)	100 gran	trar's Signat	1) /	1001/a	wer)	our &	(' /	11) X1	401
	Sta Registi	-	DEC 2 7 200			ture	also !					
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			1 - State of Maryland		artment of H		-	2000	41266
1	Dh i a		Registrar Decedent's Name (First, Middle, Last)		imodic or i	Journ	2. Date of De	Reg. No. path Day Yea	3. Time of Death
	Physici /Medi	cal	MARY HELLEMS TAYLOR		45 Ch. T.	Laurelina of Dareth	DEC	20 200	6 11.00 AM
	Examir	ner	4a. Facility Name (If not institution, give street and number) Genesis- Loch Raven Cent	er		kville		4c. County of De Bal	timore
D	Funeral Director		5. Social Security Number 233-10-5668 6. Sex 1 □ M 2 ☒ F 89	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March 28	9.8 7,1917 Vii	irthplace (State or Foreign Country) West Ginia
lay	aryland •how		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits
2	the Mary 28a-f eh	ctor	MD Baltimore			Parkvi]	lle		1 ☐ Yes 2 ☐ No
7	th with the 23a or 28	ai Dire	10e. Street and Number 8405 Harris Avenue		10f. Zip Code 2123	4		10g. Citizen of What (
727	il X I 3-0030 within 72 hours after death with the Maryland ene. then 'naturel', or Items 23e or 28e-1 ehow hadleal Exeminer must be notified at	Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2(X)No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Thite
(Ac	n 72 ho	ieted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ition furing most of work	ing	16b. Kind of Busines	s/Industry
919	V 77 5 5	omo	Elementary/Secondary (0-12) College (1-4or 5+)		okeeper	,		Insurance	Company
Manyagu		To Be C	17. Father's Name (First, Middle, Last) UNKNOWN			18. Mother's Name Melissa		, Maiden Sumame) EMS	
T CM	Wally 12 sho h and I 7 is m	ľ	19a. Informant's Name/Relationship (Type, Print) Grace N. Taylor- daughter					er, City or Town, State,	7. 1 7 1 4
	es 1 and 2 of Health		20a. Method of Disposition 20b. Pla	ce of Dispo	sition (Name of		Date	20c. Location - City	or Town, State
l*im,	Dattimore, permit. Pages 1 a Department of Hea important: if Item eny injury or othe		1 Seurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Significe of Funeral Service Licensee	Park	MemoriaL Name and Addres			Parkville,	-
a	Depermine of impo		Condial h M = tadde	E	ANS FUNE TO CREMAT	RAL CHAPE	ய் Par) Harford F kville,Mar	load Yland 21234
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Do not ent	er the mode of dying	, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death) a Due to (or as a consequent		Sep STS				
-		je.	Sequentially list conditions, if any leading to immediate	anna of):					4
RUA	be executed sicien and burial-transit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to for as a consequence of the control	nga of):					
9	cate be executed physicien and the burial-transit	dical E	d.	silce oi).					
89		/Med	IF FEMALE: 23c. If yes, outcome of pregnan	011		-7007		75.	
you O d	Hospitel or Attending Physicien: The law requires that the death certific thours after death. Ye hours after death. Funerel Director: After this certificete has been signed by the attending feller filled in by the funeral director, page 2 should be deteched for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 mo/ths? 1 □ Yes 2 □ WNo 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	requires that the de been signed by the s should be deteched to		Part II. Other significant conditions contributing to death but not result that the significant conditions contributing to death but not result to the significant conditions contributing to death but not result to the significant conditions contributing to death but not result to the significant conditions contributing to death but not result to the significant conditions contributing to death but not result to the significant conditions contributing to death but not result to the significant conditions contributing to death but not result to the significant conditions contributing to death but not result to the significant conditions contributing to death but not result to the significant conditions contributing to death but not result to the significant conditions contributing to death but not result to the significant conditions contributing to the significant conditions contributing to the significant conditions contributing to the significant conditions contributing to the significant conditions contributing to the significant conditions contributing to the significant conditions contributing to the significant conditions contributing to the significant conditions contributing to the significant conditions contributing to the significant conditions co	ting in the ur	nderlying cause give	in in Part I.		obacco use contribute Yes 2 No 3 l	to the cause of death? Probably 4 Denknown
of Vital Becords	The law re	Completed						prior to	autopsy findings available completion of cause of
Vita	ysicien: Thysicien: The is certificete director, pag	Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) Hospital: 1 \(\text{Innationt} \) 2 \(\text{Is} \)		Othe	26. Place of Death	700		
5	ding Phys h. After this funeral di	n: To	27. Manger of Death 28a. Date of Injury 2	R/Outpatien 28b. Time of Injury	28c. Injury Work	4 Mursing Ho		dence 6 Other (Sp how injury occurred	ecify)
Division	Witendin death. ctor: Af	catic	2 Accident investigation		M 101	res 2 □No	20/ 1 /		
i	pitel or At ours after of erel Direct filled in by	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Count not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, rarm, str	eet, factory, office		City or To	Street and Number or I wn, State)	Rural Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and place, inion, death occurr	and due to the ed at the time,	cause(s) and manner date and place, and de	as stated. ue to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and little of certifier Attending ph	1 Sv21	29c. License	A		29d. Date signed (Mod Dec 21	
	4		30. Name and address of person who completed cause of death (Item.	23а) (Турв,	Print)	NO RE	1.71	DEC 21.	212-11
	Sta	ate	31. Date filed (Month, Pay Year) 32. Registrar's Signatu		P 10	~Z Ur	-iimo	~ /FIE	21204

				1 - For State Registrar	Sta	ate of Ma	aryland / D	epartmei Certifica			Mental Hy	/giene	6 41267
				1. Decedent's Name (First, Middle	e, Last)						2. Date of D Month		3. Time of Death
		Physici /Medi Examir	cal	Susan Mariett. 4a. Facility Name (If not institution				4b. City	, Town, or	Location of Deat	Decemb	•	6 2:30 P ^M
				Harford Memori	al Hos	pital_		Hav	re de	e Grace		Harfor	ď
		Funeral		5. Social Security Number	6. Sex 1 ☐ M 2		e (In yrs. last birth	rs. If Under		If Under 24 Hrs Hours Min.			Birthplace (State or Foreign Country)
		Director		218-14-8964 Usual Residence of Decedent			84	15.			Sept.	29, 1922	Maryland
		death with the Maryland me 23a or 28e-f ehow r must be notified at	L	10a. Slate 10b. County			10c. City, Town						10d. Inside City Limits
		Se-f	Directo		ford		Bel	Air					1 ☐ Yes 2 ☐ XNo
		with the		10e. Street and Number	_				p Code			10g. Citizen of What	Country?
		leath	Funeral	1305 A Scottsd		IVE as Decedent	Ever in U.S.		1015	spanic Origin? (S	Specify Yes or N	USA	merican Indian,
	9	after o	Fun	1 Never Married 2 Mar	ied 1 [med Forces? ⊒Yes 2⊠0				spanic Origin? (S n, Mexican, Puer	to Rican, etc.)	Black, W	/hite, etc.
	21215-0036	filed within 72 hours after Hygiene. ither then "naturet", or Ite int, ITe Medical Examine	d by	3 Widowed 4 ☐ Divorced	Ϋ́ε	Yes, Give ear or Dates:		1 🗆 Yes	2[X] No	Specify:			White
	15-	n 72 t	Completed	15. Deceden (Specify only highe			1	Decedent's Usu Give kind of we life. DO NOT u	ork done di	uring most of wo	rking	16b. Kind of Busine Iron Rai	ss/Industry ling
	212	Jiene.	ошь	Elementary/Secondary (0-12)	Co	ollege (1-4or 5	5+)		,	Assista	nt	Manufact	
		be filed within 72 hours after death with the Marylan ital Hygiene. bd other then "naturel", or Iteme 23a or 28e-f ehow event, the Medical Examinar must be notified at	BeC	17. Father's Name (First, Middle,	Last)		- Adii	IIIISCIA				, Maiden Sumame)	
	Maryland	12 should be filed within h and Menial Hygiene. 7 le marked other then " treumatic event, tre Me	10	Calvin Grover							Grace M		
	Mar	d 2 should th and Mer ? Ie marke treumatic		19a. Informant's Name/Relations Richard C. Trac								per, City or Town, Stat	
0		an m 2 her		20a. Method of Disposition			20b. Place of I				el Alr,	Maryland 20c. Location - City	
3	E C	Pages ient of nt: If I		1 ☑ Burial 2 ☐ Cremation 4 ☐ Dongtion 5 ☐ Other (S	3 □Removi	al from State	Mt. Zic			1	-28-06		
1	Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ot		21. Signature of Funeral Scroy	/		MC. ZI			of Facility Ineral H	-20-00 •mo D	per arr	, Maryland
ļl.	8	Dep any		11-01/1	X C	sect!		1317	Cokes	sbury Rd	., Abing	gdon, Mary	land 21009
				234. Part1. Enter the disease, or shock, or heart failure. List	complication only one cau	s that caused se on each lin	the death. Do no	t enter the mo	de of dying	, such as cardiad	or respiratory a	irrest,	Approximate Interval Between Onset and Death
		Pnysician /Medical	1	Immediale Cause (Finat disease or condition resulting in death)	a	Dent	i ad	duran	~ (angust	ne Hea	A Farley	Onset and Death
10		Examiner				Due to (or as	a consequence of): 0_	can	.0	(-0)	0
2	1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to (or as	a consequence of): (4	Countries	Lisam	many)	1 gray
2	_	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Dour	te Ren	I la	سألب	٠.		· · ·	for longs
2	760,	be executed sicien end burial-transit	ical E	Tooding In dodn't Last		Jue to (or as	a consequence of):					, ,
-		ificate g phys as the	edic		d								
	Вох 68	eath certific attending pl	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If y	ves, outcome	of pregnancy 2 Petal death	3 ☐Ectopic p	reanancu			23d. Date of	delivery
_	O. E	ne dea the at hed fo	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4		time of death	5 Other (s				Month	Day Year
7	<u>o</u> .	that the died by the detached	/ Ph	Part II. Other significant condition	ns contributi	ng to death bi	ut not resulting in t	he underlying o	ause giver	n in Part I.	23e. Did t	tobacco use contribute	e to the cause of death?
5	rds	quires tha n signed uld be det	d be	Coronam	Doten	0	seose						Probably 4 Unknown
) U	Records,	law requir as been s 2 should	piet	Abrial F.	عالسا	tien					24a. Was		aulopsy findings available
-)		The Cete has page	Completed								auto perfo 1 ☐ Yes	rmed? death	to completion of cause of !? 'es 2 No
>	Vital	Physicien: 1 this certifice al director, p	Be	25. Was case referred to medical examiner?	Hospita	1: \				26. Place of Dea			
JC	of	Phys er this eral di	7: To	1 ☐ Yes 2 ②No 27. Manner of Death		Date of Injur (Month, Day		ne of	28c. Injury a Work?	4 ☐ Nursing H	ome 5 Resi	dence 6 Other (S	pecify)
,2	ion	ttending F death. ctor; After y the funera	atio	1 Natural 5 ☐ Pendin 2 ☐ Accident investi		(Month, Day	Year) Inj	ury M		es 2 □ No		,,	
	Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could in determine		Place of Inju	ury - At home, farm c. (Specify)	n, street, factor	y, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
		pitel ours el		29a. Certifier Certifyin	a Physician	To the best of	of my knowledge	death account					
		To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death. To the Funerel Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medicai	one)	ar	n the basis of	examination and/	or investigation	, in my opii	nion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and d	lue to the cause(s)
		vith con	*	29b. Signature and title of ceptified	M	M	M	D 29	c. License	00 40	2	29d. Date signed (Mo	
	j	5		30. Name and address of person 1308 Berney	who complete	ed cause of de	eath (Item 23a) (T	ype, Print)	Claud	ia Kroke	er, MD		
		Sta	te	31. Date filed (Month, Day, Year)		32 Registra	ar's Signature	e gen	seer 1	1/66	0 6		
		Registr	ar	DEC 2 7	2006	his wall En	M. A.	DEALL !					

		4	State of Maryland / Depa - State Amend item#20b, perFH, G862, 12/27/06 TI	rtment of Health and Martificate of Death	lental Hygien	e 2006 1.1268
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic	al		LIS 4b. City, Town, or Location of Death		21, 2006 8:45 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) HOSPICE OF BALTIMORE GILCHRIST CTR.	TOWSON		BALTIMORE
	Funeral		5. Social Security Number $0.08-12-9858$ 6. Sex $0.08-12-9858$ 7. Age (In yrs. last birthday) $0.08-12-9858$ 80 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 10/09/192	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	oction	10/03/131	10d. Inside City Limits
	fanylan show ed at	ō	MD BALTIMORE 10c. City, Town or Lo	PIKESVI	LLE	1 ☐ Yes 2 No
	h the N or 28a-	Director	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	s 23a c	eral	3107 WOODVALLEY DRIVE	21208 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - American Indian,
2-00-0	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 Tyes 2 N No	if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 [X] No <i>Specify:</i>		Black, White, etc. Specify: WHITE
2-0	"natur	leted	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)		Kind of Business/Industry
7 7	d within giene. er than " the Mee	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	MEMAKER		OWN HOME
and	i be file intal Hy ed oth event	Be	17. Father's Name (<i>First, Middle, Last</i>) SAMUEL I. MEYI		e (First, Middle, Maid ETH	en Surname) KUNIS
5	2 should be and Mental is marked of aumatic ev	유	19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	ng Address (Street and Number or Rui		
e, Ma	1 and 2 Health em 27 i		20h Place of Dispo			LLE, MD 212U8 Location - City or Town, State
aitimore,			4 M. Rusial 2 Cromotion 2 Pamoval from State	E HENKEW CEM 12/2	24/2006	REISTERSTOWN, MD
Balt	permit. Page Department (Important: If any injury or once.		21. Signature of Funeral Service Licensee			ON & BROS., INC. IKESVILLE, MD 21208
ı	351		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate dause (Final disease or condition a.			Approximate Interval Between Onset and Death
1	Physician /Medical Examiner		resulting in death) Due to (or as a consequence of):	gav sinaary		VIVIVIS
/	uted d ansit	Examiner	Sequentially list conditions, if any, leading to instructions cause. Enter Underlying Cause (Disease or injury that initiated events			
8760,	ate be executed hysician and the burial-transit	dical Exa	resulting in death) Last Due to (or as a consequence of): d.			
Ö	death certifica attending ph I for use as th	/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery
P.O. Box	the death y the atter ched for u	Physician/Med	Live bitti 2 Li eta deati bi	□Ectopic pregnancy □ Other (specify)		Month Day Year
	quires that the de n signed by the a lid be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the to	underlying cause given in Part I.		co use contribute to the cause of death?
Division or Vital Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed			24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?
Vital	iclan: certifica ector, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othori	ath (Check only one)	e 6 DOther (Specify) M.) SP(C
10	g Physical this reral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	#IL 3 DOA 4 Nursing F	28d. Describe how i	
ision	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, s	M 1 □ Yes 2 □ No	28f. Location (Stree City or Town, S	et and Number or Rural Route Number,
2	tat or / rs after al Dire	Certi	4 Hornicide Building, etc. (opposity)			
	e Hosp 24 hou e Funei etely fil	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal of the control of the	ain occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the caus urred at the time, date	e and place, and due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
)	: 12		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)		
	10		ARMAN I CHAMUES MA 6565 N	I Charles St Zone	we 2120	+
	Si Regis	tate trar	31. Date filed (Month, Day, Year) DEC 2, 7, 2006 32. Registrar's Signature	Colo		

06-09437 Roy John Whitaker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	R	- For State Certificate of Death	Reg. N	No. 2000	11000
Physician Medical Examine	<i>''</i>	, sossession reasons (med medical property)	Date of Death Month Da December 11	y 2006	3. Time of Death U
Vieulcai Examinic		Roy John Whitaker 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	December 11	4c County of Death	
		801 Stevenson Road Severn		Anne Arundel	
Funeral Director		1 M 2 F 57 Yrs. Months Days Hours Min.	B. Date of Birth (N	Foreig	hplace (State or unk n untry)
any		Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits
ž .	_	MD Anne Arundel Severn			1 Yes 2 X No
Maryland 28a-f show 3 at once.	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cour	try?
th the Maryland 23a or 28a-f sho notified at once.		801 Stevenson Road 21144		USA	and Indian Block
r death wi	Fune	11 Marital Status unk 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 1 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ric		14. Race - Americ White, etc. Specify: b	lack
hours afte natural", Examiner	핡	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired		b. Kind of Business/li	ndustry unk
6 n 72 hc nan "ng ical Ex	Seted	Elementary/Secondary (0-12) College (1-4 or 5+)	,		
-0036 1 within 72 giene ither than '	⊏ L	unk 17. Father's Name (First, Middle, Last) unk 18 Mother's Name (Fi	irst, Middle, Maid	den Surname)	unk
215-(oe filed vontal Hyginked oth ent, the	S Re				
MD 21215-0036 d 2 should be filed within 7 tht and Mental Hygiene n 27 is marked other than numatic event, the Medica		19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rura 111 Page 1111 Page			Zip Code)
e, MD I and 2 sho Health and item 27 is	-	O.C.M.E. 111 Penn Street Baltin 20a Method of Disposition 20b. Place of Disposition (Name of cemetery,		21201 Oc. Location - City or	Town, State
<u>'</u>		1 Burial 2 Cremation 3 Removal from State crematory or other place)			
Baltimo permit Pag Department Important: injury or of	H	4 Donation 5 X Other Specify in State 21. Signature of Ronald Service Wage Director State Anatomy Board	655 W. 1	Raltimore	Street
Depri		Baltimore, MD 21201			
Physician /Medical		23a. Part I. Enter the disease, of demplications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.	espiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease Due to (or as a consequence of):			Death
		Sequentially list conditions, b			
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.			
d sit	/Medical Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed in and illeransit	<u>8</u>	MENDED #220 DTT 27 porME 2962 1/2/07 TT			
760, ficate be exe	eg-	#23a,PII,27,perME, g863, 1/2/07 TT IF FEMALE: 23c. If yes, outcome of pregnancy	I	23d Date of delivery	
687 vertifical		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnance 4 Pregnant at time of death 5 Other (Specify)	у	Month D	ay Year
30x death of re atter	Physician	4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
, P.O. Box 68 res that the death certifus signed by the attending be detached for use as	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		cco use contribute to	the cause of death?
S, P uires ti	ed b	Chronic obstructive pulmonary disease	24a. Was an		topsy findings available
cords, law requir has been s	Completed		autopsy	prior to c	ompletion of cause of
tal Rec	녌	25. Was case referred to medical 26. Place of Death (Check onli	1 Yes 2	No 1 V	s 2 No
Vital hysician this certi	<u>m</u>	25. Was case referred to medical examiner? 1 ✓ Yes 2 No		sidence 6 🗸 Other	: Scene
n of \ ing Phy After th	의	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28	3d. Describe how	injury occurred	
ion trendin death tror: A	aţio	1 X Natural 5 Pending 2 Accident Investigation			
Division of Vital Records, P.O. Box 68' Hospital or Attending Physician: The law requires that the death certifi 24 hours after death. Funeral Director: After this certificate has been signed by the attending tell filled in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28 (Specify)	3f. Location (Stre or Town, State		ral Route Number, City
Lospita Hospita 4 hours Junera	- 1	4 Homicide 29a Certifier A Constitution To the hort of my knowledge, death occurred at the time, date and place, and div	e to the cause(s) and manner as state	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.			
E 3 E 8	ĕ	29b Signature and title of certifier 29c. License number		9d Date signed (Moi	
		Unal 2 O.C.M.E.		December 11, 20	006
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
Sta	ate	31. Date filed (Month Day, Year) 32. Registrar's Signature			
Registr	rar	DEC 2-7 2006 Alexander 15			

			For Amend #1&19a = State Registrar	Plate Miy ATVIA	C863 epartme <i>Certifica</i>	nt of Health and I	Mental Hygier	2006	41270
	Physici		1. Decedent's Name (First, Middle, Last	Wallac	e Lavinia	Wallace	2. Date of Death Month	22 2°006	3. Time of Death $Q \circ A_M$
**.	/Medic Examin Funeral		5. Social Security Number 6. Se	e	last birthday) If Und	y, Town, or Location of Death	n	Balt	More
	Director		Usual Residence of Decedent 10a. State 10b. County	1 02	Yrs.		NOV.5,1	924 IVIa	ryland Od. Inside City Limits
	ith with the Marylar 23a or 28a-f show ust be notified at	rector	Md. NA	E		O re Zip Code	10g. (Citizen of What Cour	1 Yes 2 □ No
	s I and 2 should be filed within 72 hours after death with the Maryland Health and Meniat Hygiene. Health and Meniat Hygiene. Item 27 is marked other than "natural; or Itama 23a or 28a-f show other traumatic avent, the Madical Examinar must be notified at	Funeral Director	5715 Park	Heights 12. Was Decedent Ever in U Armed Forces?	Ave.	21215 sedent of Hispanic Origin? (S becify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
215-0036	hours afte tural', or i	þ	1 Never Married 2 Married 3 Media 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes		166	Specify: BL	ack
21215-	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", surmatic avent, the Medical Exa	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation the completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of v life) DO NOT	vork done during most of wor	rking	Domes	stic
Maryland 3	ould be filed Mental Hygi arked other atto event,	To Be C	17. Father's Name (First, Middle, Last) Samue	Crawfor	d	18. Mother's Nar	me (First, Middle, Maid Stine	en Sumame) Mas	on
	is 1 and 2 sho of Health and Item 27 is my other traumy		19a. Informant's Name/Relationship (7.	Dean	19b. Mailing Addre	ss (Street and Number or Ru	Balto Date 20c.	Md. S	21230
Baltimore	Page ment o ant: if ury or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	butus 1		30/2006 E	Balto.	Md.
Ball	permit. Depart Import any in		21. Signatur of Funeral Service Lisens	L. Bu	122 Name 20 Se 2222	and Address of Eacility Ph. L. Ru S	s Fyrera	d Home	P.76
	Physician		shock or heart failule. List only of Immediate Cause (Final disease or condition	lications that caused the deat one cause on each line.		ode of dying, such as cardiad	c or respiratory arrest,		Approximate Interval Between Onset and Death
1 24	/Medical Examiner		resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consect					
	be executed ician and burial-transit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq c.					
8760,	0 0	cai		d.	quence or).				
.O. Box 68	that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3 Ectopic			23d. Date of delive Month	ny Day Year
<u>α</u>	8 E 8	þ	Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tobacc	o use contribute to the	i
Division of Vital Records,	The law ate has b	Completed					24a. Was an autopsy performed	prior to condeath?	psy findings available inpletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ 📆 o	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Othor	ath Check only one	6 □Other (Specifi	·)
ion of	Witer	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 \(\text{Yes} 2 \(\text{No} \)	28d. Describe how in		
Divis	E E E	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fact fy)	ory, office	28f. Location (Street City or Town, St		l Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	edical	29a. Certifier (Check only one)	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurr ation and/or investigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause urred at the time, date a	e(s) and manner as si and place, and due to	ated. the cause(s)
_	To the vithin 2 To the complet	M	29b. Signature and title of certifier Rayman Mills	MA		29c. License number		Date signed (Month,	Day, Year)
4	9		1		m 23a) (Type, Print)	D 47683	wa ma	21186	
*	Sta Regist		30. Name and address of person who of Multi- 31. Date-field (Month, Day, Year) DEC 2	7 2000 Segister's Sign	ature	and i			

State of Maryland / Department of Health and Mental Hygiene 006 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** WALTER L. WHITACRE DECEMBER 25, 2006 7:30 P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 203 WENDY LANE GLEN BURNIE ANNE ARUNDEL 6. Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Yrs. Director 218-36-4954 66 APR. 20, 1940 WEST VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits wode in than "natural", or itame 23a or 28a-f ehov The Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MARYLAND ANNE ARUNDEL GLEN BURNIE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 WENDY LANE 21060 UNITED STATES Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No If Yes, Give ARMY Year or Dates: 195 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CHEMICAL INDUSTRIAL MECHANIC 12 should be filed w h and Mental Hygier 7 is marked other ti 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HILDA IRENE KLINE LEE CLIFTON WHITACRE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 of Health of Item 27 I GLEN BURNIE, MD 21060 PHYLLIS WHITACRE / WIFE 203 WENDY LANE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
important: if Itel
eny injury or oth DECEMBER 1 □ Burial 2 ☑ Cremation 3 □ Removal from State onation 5 Other (Specify) 4 27, 2006 METRO CREMATORY CATONSVILLE, MARYLAND 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A. ure of Funeral Servide Licensee 21. Sign 421 CRAIN HWY. S.E. GLEN BURNIE, MD Approximate Interval Between Onset and Death 23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition once added **Physician** /Medical resulting in death) Examiner -1000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) cete has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificete has 1 ☐ Yes 2XXVo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 XNo 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burne des 21061 qualiant Rd aro 600507 85 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 1 State of Maryland / Department of Health and Mental Hygiene per verb., G862, 12/27/06/bb Death 1. Decedent's Name (First, Middle, Last) Lawrence White 2. Date of Death Month Day Physician Year White LAWRENCE Dec 01 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Battimore Bon Secours MO NA HOSPITAL 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Min 248-40-1126 Director 011 01 1929 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at BALTIMORE Director NA 1 Yes 2 No MO 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 W. LAFAYETTE AVENUE Funeral عال12ك U.SA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **⊠** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No þ Specify Specify: 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LABORER 11 1H GRADE NA BETH . STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If Item 27 Is marked old any Injury or other traumatic ever ance. EDWARD WHITE ပ Lucy Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. LAFAYETTE AVE., ELOISE WIFE WHITE BALTO mo 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MT. XION 12.09.06 BALTO. MO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATE PIKE, BATTO. Mp 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) action Physician MUOCArdia /Medical Due to pras a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be execut Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð aranoma Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ◯ No 25. Was cas referred to medical examiner 1 Nospital Hospital autonsy perform 2 No Hospital or Attending Physician: 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturai 2 ☐ Accident 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) The the I the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 120034730 12006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JONGULAN

31. Date filed (Month, Day, Year)

DEC 2

2006

DHMH 17 Rev 1/2001

2000

32. Registrar's Signature

W. Baltimore STREET

Baltimore

			1 - For State Registrar	State o	f Marylar			Health and	Mental Hyg	iene 006	41273
YO.	Physici /Medi		Decedent's Name (First, Middle, Jack Edwin Wil.	,					2. Date of Deat Month	Day Year	3. Time of Death $4:40 \ \text{A}^{\text{M}}$
0	Examir		4a. Facility Name (If not institution, 615 Cherry Hill	give street and nur	mber)		4b. City, Town,	or Location of Death		4c. County of Death	
.86	Funeral Director		5. Social Security Number 187–05–4444	6. Sex 1⊠M 2□F	7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs.	8. Date of Birth (Month, Day, Jun. 10	Year) 9. Birth	nplace (State or Foreign untry) nsylvania
	nyland thow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	or death with the Maryland tems 23a or 28a-f show ar must be notified at	by Funeral Director	Maryland Har	rford		Street	10f. Zip Code		10	0g. Citizen of What Co	1 ☐ Yes 2 No
	th wit	a D	615 Cherry Hil	L Rd.			211	54		USA	
\		Iner	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U	l.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puert		14. Race - Amer Black, White	
lm 036 036	hours after tural', or Ite	by Ft	1 ☐ Never Married 2 ☐ Marne 3 🙀 Widowed 4 ☐ Divorced		2 🗌 No	_	1 ☐ Yes 2 ☐ No		o riioari, sto./		hite
(215-0	s 1 and 2 should be filed within 72 hours afti f Health and Mental Hygiene. Item 27 is marked other than "natural", or I other traumatic avent, the Medical Exam	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1	40x 5 x \	16a. Dece (Give life.	dent's Usual Occi kind of work don DO NOT use retir	upation e during most of wor ed)	kıng	16b. Kind of Business/I	ndustry
2 2	filed wit Hygiene other the	Com	8			Utili	ty Worke	er	G	as & Elect	ric Company
7 5	be filed tal Hygie d other l	Be	17. Father's Name (First, Middle, La				_	18. Mother's Nan	ne (First, Middle, M		11
√ <u>√</u> 8	2 should be and Mental Is marked o	2	John (unk) Will						e (unk) C		
CK U	nd 2 sh alth and 27 is m		19a. Informant's Name/Relationshi Shirley Barry/ I							City or Town, State, Ziaryland 21	
e D	is 1 and if Health item 27 other tr		20a. Method of Disposition	augireer	20b. F		sition (Name of natory or other pl.		_	arytana 21. 20c. Location - City or T	
万章	ages ent of it: If it y or o		Bural 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spy		State						
Baltimore	permit. Pages Department of I Important: If ite any injury or of		11 11 61	censee	DL.	22	Cemeter Name and Addr	and the same of th		West Cheste	er, PA
	20 E = 9		/1-0/ R/N	600	02	- 1	317 Coke	sbury Rd.	. Abinad	on, Marylar	nd 21009
	Physician	8 8	23a. Parti. Enter the disease, or conshock, or heart failure. List of Immediate Cause (Final	omplications that calls on each of the cause on each	aused the deat ach line.	h. Do not ent	er the mode of dy	ring, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical	1	disease or condition resulting in death)	a Due to (or as a conseq	uence of):			0220	CLATION	
	Examiner		Sequentially list conditions,	b	SCH	18011	C HE	BART !	D1566	HG.	
	pe jisi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):					
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). Box 6	the Hospital or Attending Physician: The law requires that the death certifica hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy inpletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Wo 9 ☐ Unknown	23c. If yes, outo 1 ☐ Live bi 4 ☐ Pregna 9 ☐ Unkno	irth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pregnand Other (specify)	су		23d. Date of deliv Month	ery Day Year
P.O.	that the ed by detach		Part II. Other significant condition	s contributing to de	eath but not res	ulting in the ur	nderivino cause o	iven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	w requires been sign should be	ed by							1 🗆 Yes		
S	has begge 2 sho	Completed							24a. Was an	24b. Were auto	opsy findings available
<u>~</u>	The ate h page	Com							autopsy perform 1 Yes 2	ed? death?	
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						th (Check only one		
Ę	ding Physician: The n. After this certificate hi funeral director, page	²	1 Tyes 2 No			ER/Outpatien	t 3□ DOA Ot	her: 4 Nursing Ho	ome 5 Resider	nce 6 Other (Speci	fy)
5	ding 1 h. After funer	ilon	27. Manner of Death 1 Natural 5 Pending		h, Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe how	w injury occurred	
Division of Vital Records,	or Attendi after death, Director: A in by the fu	rtifical	2 Accident investigal 3 Suicide 6 Could no 4 Homicide determine	be 28e. Place	of Injury - At ho	ome, farm, stre	eet, factory, office]Yes 2 □No	28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
_	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier Cartifying	Physician: To the	best of my kno	wledge, death	occurred at the t	ime, date and place,	and due to the cau	use(s) and manner as s	stated.
	thin 2 the 1 the 1 mplet	Med	one) 29b. Signature and title of certifier	and mann	er stated.			se number			
	To To	-	Signature and the or certifer	Al-P-	11.0	MD			1	d. Date signed (Month,	OOL
	1		30. Name and address of person wh	o completed cause	of death (Item	1 23a) (Type. I	Print)	-011	/	12/23/2	
(D'A		HANUSHA, SIR	ITHARA	1,2112	BOLD	ir RoA	D, 8417	E 10, FR	12/23/2 AUSTON, M	021047
3.5	Sta Registr		31. Date filed (Month, Day, Year) PFC 9 7 20	1.56	egistrar's Signa	ture	25				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 22, 2006 Physician **ESTHER** MARLENE WASSERMAN 8:33 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3934 CHAFFEY ROAD RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/13/1952 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Days 1 ☐ M 2 🗸 F 54 217-62-0114 VΑ Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3934 CHAFFEY ROAD 21133 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CARE GIVER STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN WASSERMAN MILDRED FRANK ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BENJAMIN WASSERMAN / **FATHER** 3934 CHAFFEY ROAD - RANDALLSTOWN, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) KOLK 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 □Removal from State KNESSETH ISRAEL ANSHE 12/24/2006 4 □ Donation 5 □ Other (Specify) DUNDALK, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Matt 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,—shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intarction **Physician** OLCEVIL /Medical Due to (or as a consequence of): Examiner rapox if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons uence of): Examiner The law requires that the death certificate be executed عم the burial-tran Due to (of as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Dinknown for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 21\(\tag{N} or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 1 ☐ Yes 2 ☐ N 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Desidence 6 □Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of De 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 🕽 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar DFC 2 7 20

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

porte

		1	1 - For State Registrar	State of N	Marylan	d / Depa <i>Cei</i>	artmer rtifica:	nt of He te of D	ealth a Death	ind M		giene Reg. No.	006	41275
£ .	Di sisi		1. Decedent's Name (First, Middle, Last)								2. Date of De.	ath Day	Year	3. Time of Death
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79		÷ .	10609 Blackstone A					nelter		3411 1			nce Geo	
100	Funeral		5. Social Security Number 6. Sex	M 218 F		(ast birthday) Yrs.	Months		If Under 2 Hours	Min.	8. Date of Bird (Month, Da	v. Year)	9. Birth	place (State or Foreign
2	Director		243-32-4858 Usual Residence of Decedent		80						July 3	1, 19	26 Wash	ington,DC
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mary 4 sh	ţō	DC		W	ashing	ton							1⊠Yes 2□No
	r 28s	rec	10e. Street and Number					p Code				10g. Citiz	en of What Cou	intry?
	h with	a i D	1400 Downing St.	N.E. #2				200	18			U	SA	
	72 hours after death with the Maryland Insturet; or items 23s or 28s-4 show Useal Exemities out the motified at	by Funeral Director	11. Marital Status	2. Was Decede Armed Force		.S. 13.	Was Dece	dent of His	panic Orig	jin? (Spe	cify Yes or No Rican, etc.)		4. Race - Amer Black, White	
ထွ	after or its	F	1 ☐ Never Married 2 ☐ Marned	1 ∐Yes 2¼ If Yes, Give			1 🗆 Yes		Specify:	, 1 001101	ticari, otc.)		Specify:	, 616.
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2	Hygie ther nt.		17. Father's Name (First, Middle, Last)				OOK		18. Mother	r's Name	(First, Middle,			II HOSPICAL
an	d be sold of control o	o Be	Broadie Atwater								e Harr		,	
<u>-</u>	Shoul Thank	၉	19a. Informant's Name/Relationship (Typ	e, Print)	,	19b. Mailir	ng Addres	s (Street a	nd Number	r or Rura	l Route Numbe	er, City or	Town, State, Zi	p Code)
Ž	nd 2 lith a 27 is r treu		Debra Carter/Daugh	nter		1060	9 B1a	acksto	one A	ve.	Chelte	enham	, MD 20	623
ē,	s 1 a of Hea	1	20a. Method of Disposition		,	Place of Dispo	sition (Na	me of other place) 1	D	ate	20c. Loc	ation - City or T	own, State
E	Pege not: if iry or		1 Burial 2 □ Cremation 3 □ Real Cremation 3 □ Real Cremation 5 □ Other (Specify)	emoval from Sta	10	. Linc			-	2-12	-2006	Bren	twood,	Md.
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s 4 show any injury or other treumatic event. The Medical Expiritment and be notified at ance.		21. Signature of Funeral Service License	е /	00	M.	2. Name a	nd Address	of Facility	ra1	Home,	Inc.		
Ω_	89 = 89		p. 1.111a	rshall									DC 200	11
聖意			23a. Pag1 Enter the disease, or complice shock, or heart failure. List only on	cations that caus e cause on each	sed the deat in line.	h. Do not ent	ter the mo	de of dying	, such as o	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Cardio	pu1mo	nary F	ailu:	ce						Oriset and Death
	/Medical Examiner		resulting in dealh)	Due to (or	as a conseq	uence of):								
		ي	Sequentially list conditions, b	Carcin	ioma L									
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	203 10 (01	as a senseq	331100 017.								
	al-tra	Хаг	that initiated events c resulting in death) Last		as a conseq	uence of):								
8760,	death centificate be executed e ettending physicien and nd for use as the burral-transit	edical												
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Вох	eath certific ettending pi for use as t	N/U	23b. was decedent pregnant	3c. If yes, outcor			Tectopic r	pregnancy				2	3d. Date of deliv	,
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9	w requires been sign should be	ted	Hypertension									103 2		
Sec.	8 S	Completed	Sick Sinus Syndron	ne							24a. Was			opsy findings available ompletion of cause of
<u>e</u>	ate peg		Permanent Pacemake	er							1 ☐ Yes	2 🔯 No	1 ☐ Yes	2 No
₹	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		leno.		Othe			(Check only o		***	Der Homo
of	Phys r this ral di	1: To	1 Yes 2 No	28a. Date of I		ER/Outpatier 28b. Time of		28c. Injury Work	4 🗆 1401		ne 5 ∟ Resi 28d. Describe I			Tr. Home
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Division of Vital Records,	i or Attending after death. Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of			reet, facto	ry, office		2			Number or Ru	ral Route Number,
á	ital or irs afte rai Diri	Certification:	4 Homicide	building,	etc. (Specil	<i>Y)</i>					City or To	wn, State)		
	Hosp 24 hou Fune Fune	dicai	29a. Certifier (Check only one)		s of examina									
	To the within 2 To the complet	Me	29b. Signature and title of certifier			_	- 1	c. License	number		DC	29d. Date	signed (Month	, Day, Year)
)			Du C					MD	121	149		3,	2/8/06	
)	(3)		30. Name and address of person who co											
_	1		Amjab Rasul, M.D.			n St NI		4 Wa	shing	gton	, DC 20	017		
	Sta Regist		31. Date filed (Month, Day, Year) NFC 1 2 2006	32. Reg	strars Signa	ped)	5							

			For State Registrar	State of Mar	yland /		rtment c tificate			Mental H	lygiene Reg. No	4 U U D	41276
			Decedent's Name (First, Middle, Last	t)						2. Date of Month	Death		3. Time of Death
	Physicia /Medic		Demera Ayana							Dec.	$4, 20^{Da}$	06	11:53 A M
	Examin		4a. Fecility Name (If not institution, give	street and number)					_ocation of Dea	ath	4c	. County of Dea	th
			Holy Cross Hospital						Spring			Montgom	
I	Funeral Director		5. Social Security Number 6. Security Number 219-35-3221		(In yrs. last b	Yrs.	If Under 1 Y Months D	ays	Hours Mi	8. Date of (Month, Sept.	Day Year	C	thplace (State or Foreign buntry) thiopia
	pur *	}	Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, To	wn or Lo	cation						10d. Inside City Limits
	Aaryle I eho	ъ	Maryland Montgome		Silve								1 X Yes 2 No
	28a-	ect	10e. Street and Number	Ly	DITA	er ol	10f. Zip Co	de			10g. Ci	tizen of What Co	ountry?
	3a or	Funeral Director	4018 Ferrara Driv	<i>r</i> e			2090	06			Eth	iopia	
	death ms 2	hera	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. V	Vas Decedent	t of His	panic Origin?	(Specify Yes or erto Rican, etc.)	No-	14. Race - Ame Black, Whi	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23e or 28a-f ehow eny Injury or other traumatic event, the Medical Exertion or their traumatic event, the Medical Exertion or their multiped at once.	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:			Yes 22		Specify:	sito filoan, etc.)		Specify: B1	
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Maryland 21215-0036	be fill htal H d off	Be	17. Father's Name (First, Middle, Last)							ame (First, Mid Jote	зів, маідег	i Sumame)	
2	d Mer narke	ဥ	Ayana Tola 19a. Informant's Name/Relationship (7)	Tuna Print!	10	Oh Mailin	a Address (S	troot a		Rural Route Nui	mher City	or Town State	Zin Code)
<u>N</u>	d 2 sl th and 17 is r traur	1.8		(wife)			•			Silver	-		20906
	1 an Heal Heal tem 2		20a. Method of Disposition		20b. Place	of Dispo	sition (Name	of		Date	-	ocation - City or	Town, State
ᅙ	Pages ent of ht: If if		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		1	-	natory`or othe leaven	r piace		2/8/06	Sil.	ver Spr	ing, MD
altimore,	artmoortar		21. Signature of Funeral Service Licen			22	. Name and A	ddress	s of Facility M	cGuire			
ä	Departiment of the post of the		Undra	2 Show	palen					N.W.,			20012
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	he death. D	o not ent	er the mode o	f dying	, such as card	iac or respirator	y arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cardiom		hv							Onset and Death 9 years
	/Medical		resulting in death)	Due to (or as a									
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	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to [or as a	consequenc	ce off:							
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687	ficate g phys	edical		. d.							- 1		
Вох	anding use a	Z M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		ath 3	Ectopic pregr	nancy				23d. Date of de	
œ.	deati	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tir			Other (special				-	Month	Day Year
<u>Р</u> .	thet the death certificed by the attending posteriors as	hys	9 Unknown					-					
	Se Ge	Completed by Physician/Me	Part II. Other significant conditions of Acquired Immune			•	nderlying caus	se give	n in Part I.		id tobacco ☐ Yes 2		o the cause of death? robably 4 □Unknown
oro	w requir been si should	eted	- required immune	defferency	3 y Har	LOME				-		-	
Sec	e law has t	mple								24a. W	nas an utopsy enformed?	prior to death?	utopsy findings available completion of cause of
a	n: Th licete r. pag		25 14							1 ☐ Ye	s 2⊠No		s 2 No
Vital Records,	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	25 NEB/	Outpatien	t 3□ DOA	Othe		eath <i>(Check on</i> Home 5 ☐ R		5 □Other (So	acity)
Division of	Phy er this	n: To	27. Manner of Death	28a. Date of Injury	281	b. Time of		Injury		28d. Descri			ony
<u>o</u>	Attending r death. ector: After by the fune	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear)	Injury	М		r ′es 2 □No				
<u>Vis</u>	r Atte er dei recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.		, farm, str	eet, factory, o	ffice		28f. Locatio City or	n (Street a Town, Stat	nd Number or F e)	lural Route Number,
Ω	ital or urs efte ral Dire												
	To the Hospital or Attending Physician: The Is within 24 hours effer death. To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page:	Medicai		ysicien: To the best of niner: On the basis of e and manner state	xamination								
	To th within To th compl	Me	29b). Signature and title of certifier	•			29c. L	icense	number		29d. Da	ate signed (Mon	th, Day, Year)
)	2		() 100 Hack 1	LLLL	N	Un	D	43	3228		12	15/00	3
	~		30. Name and address of person who	completed cause of dea								1	
			Lynette H. Posor				on Str	eet	#230	Silve	r Spr	ing, MD	20910
	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 2	32. Registrar	's Signature		sere!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** DECEMBER 6, 6:33 PM 2006 RUTH I. ADAMS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖔 F Months Hours Yrs. Director 577-32-7430 WEST VIRGINIA NOVEMBER 14,1927 79 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director SILVER SPRING MARYLAND. PRINCE GEORGE'S 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3144 GRACEFIELD ROAD 20904 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: 3 X Widowed 4 ☐ Divorced Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CATHERINE BUTLER ျှ JAMES CUSTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8112 POWHATAN STREET, NEW CARROLLTON, MARYLAND 20784 JOSEPH L. ADAMS - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Important: if it any injury or o Department of 1
☐ Burial 2
☐ Cremation 3
☐ Removal from State 4 Donation 5 Dother (Specify) GATE OF HEAVEN CEMETERY 12/11/2006 SILVER SPRING, MARYLAND 21. Signature of Funeral Service Lice see 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC 11800 NEW HAMPSHIRE AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failule. List only one cause on each line. Immediate Cause (Final **Physician** ACUTE STROKE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Box 68760 physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Day Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 🗓 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ SEVERE TREMOR 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No PNEUMONIA 24a. Was an autopsy page 1∐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 🖔 Inpatient 2 ER/Outpatient 3□ DOA ٩ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 X Natural 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours

To the Funeral 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEC

IRINA Y. RUBAN, M.D.,

11

1500 FOREST GLEN ROAD, SILVER SPRING, MARYLAND 20910 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

29c. License number

D0063343

29d. Date signed (Month, Day, Year)

DECEMBER 8, 2006

			For State Registrar	State of Ma	aryland / D	epa <i>Cen</i>	rtment of He tificate of D	ealth and Death	Mental Hygi	enez () () (5 41278
E			Decedent's Name (First, Middle, Last,)					2. Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic	_	Donald P. Amorin						Decembe	r 8, 2006	9:24 P M
	Examin		4e. Facility Neme (If not institution, give				4b. City, Town, or I	Location of Dea	ath	4c. County of De	
L		a) *	41 Mill Pond Driv		a //a .um lant hint	th double	Rising	Sun If Under 24 Hr	S. R. Date of Birth	Cecil	
	Funeral		5. Social Security Number 6. Sec. 1575-32-1269	K XM 2□F 7. Ag	e (In yrs. last birt	ricay) _ Yrs.	Months Days	Hours Mir		Year) 1936	Sirthplace (State or Foreign Country) Hawaii
	Director		Usual Residence of Decedent		, ,				Tripreses 10	, 1700	
	yland		10a. State 10b. County		10c. City, Town	or Loc	eation				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	a-f e	ctor	Maryland Ceci	e	Rising	Su	n				
	or 28	Directo	10e. Street and Number				10f. Zip Code		10	g. Citizen of What	
	death with the Maryland ms 23a or 28a-f ehow		41 Mill Pond Driv		F -:- 110	40.14		911	(Constitution of No.	USA	merican Indian,
	d within 72 hours after death with the Marylan piene. r than "natural", or Itams 23s or 28a-f ehow the Maryled Exertines in the malified at	Funerai	11. Marital Status 1 ☐ Never Married 2 🕱 Married	12. Was Decedent Armed Forces?				n, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	Black, W	
5	within 72 hours after ene. than "natural", or Ita	by F	3 Widowed 4 Divorced	1 X Yes 2 1 If Yes, Give Year or Dates:	1953-54	1	Yes 2X No	Specify:		Specify:	Vhite
9500-61212	2 hou	ted	15. Decedent's Edu (Specify only highest grad	cation	16a.	Deced	ent's Usual Occupat	tion	nakina	6b. Kind of Busine	ss/Industry
	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		kind of work done du OO NOT use retired)	anny most or m	9	5 / 6	
	ygien ygien nar th	Con	12			Bark		40 Mash - d - M	ame (First, Middle, N	Barber S	hop
and	be filed stal Hygie of other event, it	Be	17. Father's Name (First, Middle, Last) Eugene Amorin						a Tixeria	alderi Sumame)	
5	should ind Men s marks umatic	2	19a. Informant's Name/Relationship (T)	one Print)	19h	Mailin	o Address (Street at		Rural Route Number,	City or Town. State	a. Zip Code)
Mar	d 2 T is		Janice T. Amorin/						Sun, MD 2		
ē,	s 1 and f Heali item 2 other		20a. Method of Disposition	0			sition (Name of natory or other place			Oc. Location - City	or Town, State
9 E	Pages nent of int: If it iry or o		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			-	aptist Cer		-13-2006	Risina S	un, Maryland
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licen	ee O	<i>J</i> ·				al Home, 1 Rising Si		
			23a. Patt1. Enter the disease, or comp shock, or heart failure. List only o	lication that caused	the death. Do r	not ente	er the mode of dying	, such as cardi	ac or respiratory arre	ist,	Approximate
			shock, or heart failure. List only o	ne caude on each li	ne.		1 10-1	Sala	c		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as	a consiliuence	of):	Lateral	JCIENO	31-2		
	Examiner					,					
'n	THE SAL	ner	Sequentially list conditions, if any, leading to immediate cause. Enter unperlying	b. Due to (or as	a consequence	of):					
	nd nd transi	Examiner		c							
Ď,	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or as	a consequence	Of):					
8760	physic	dical		d							
×	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Φ	IF FEMALE:	23c. If yes, outcome	of pregnancy					23d. Date of	delivery
. Box	atten atten for u	by Physician/M	23b. Was decedent pregnant in the past 12 months?	4□Pregnant a	2 Fetal death time of death		Ectopic pregnancy Other (specify)			Month	Day Year
Ŏ.	that the de led by the a detached i	nysi	1 Yes 2 No 9 Unknown	9□ Unknown							
Division of Vital Records, P.O	s that ined b e deta	y P	Part it. Other significant conditions co	ntributing to death b	out not resulting in	n the un	derlying cause give	n in Part I.	23e. Did tob		to the cause of death?
ğ	w requires that been signed I should be det								1 ☐ Ye	s 2 124√10 3 🗆	Probably 4 Unknown
ပ္သ	e law re has be- je 2 sho	Completed							24a. Was as	y prior	autopsy findings available to completion of cause of
ř		Com							perform		i? ′es 2□ No
ita	i cian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	I I a a cita i			Otho		eath (Check only on	9)	
5	Physi this c	10	1 Tes 2 No	Hospital: 1 ☐ tnpati		tpatien		4 Nursing	Home 5 Reside		pecify)
מ	ting f	ion	27. Manner of Death 1 Autural 5 Pending investigation	(Month, Da	y Year)	njury	28c. Injury Work M 1 □ Y	? fes 2 □ No	200. 50001150 110	w injury occurred	
18	Attending Physician: If death. ector: After this certification by the funeral director.	fica	3 Suicide 6 Could not be	28e. Place of tn	jury - At home, fa	arm, stre	eet, lactory, office				Rural Route Number,
20	al or / s after I Dire	Certification:	4 Homicide	building, e	tc. (Specify)				City or Town	, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Phy (Check only ane) 2 Medicat Exam	vsician: To the best iner: On the basis of and manner st	of examination an	e, death	occurred at the tim restigation, in my op	e, date and pla pinion, death oc	ace, and due to the ca courred at the time, da	tuse(s) and manner ate and place, and	as stated. due to the cause(s)
	o the ithin i	Med	29b. Signature and title of certifier	and manner st			29c. License	number	2	9d. Date signed (Me	onth, Day, Year)
)	⊢≯⊢ŏ		Robert ama	etelu.	M		D 009	53675	- /	2/11/06	
1	ot IVA		30. Name and address of person who o	completed cause of a	death (ttem 23a)	(Type,	Print)	5,0,20	214, EJK	from Men	21921
a	Sta		31. Date filed (Month, Day, Year)		rar's Signature			. 50/74	J. 1, C 17	TOPL PRO	
	Regist	rar	DEC 1 1 2006	Musica	15 K	150					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ [] Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) DECEMBER DE FRANCES BEILMAN ANDERSEN 2006 07:00 AM 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) CHESTERTOWN KENT HERON POINT 8. Date of Birth (Month, Day, Year) 07/24/1917 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Hours Days 1 □ M 2 🗓 F 84 NY 128-07-3608 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location. 10a State 1X Yes 2 □ No MD KENT CHESTERTOWN 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21620 USA 437 HERON POINT 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RUTH G. HITESMAN OTTO CONRAD BEILMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8002 WINTER CIRCLE, DOWNERS GROVE, IL 60516 ERIK L. ANDERSEN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 12/09/2006 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTASES month Due to (or as a consequence of) CANCER URINS EAST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 Yes 2 No DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No 26. Place of Death Check onl one Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death

Examiner burial-transit Division of Vital Records, P.O. Box 68760, attending physician as the t esn certificate has After

Physician

/Medical

Examiner

Funeral

Director

rithen "naturel", or items 23e or 28e-f show the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
nn: If item 27 is marked other than "naturel; or flee any or other traumatic event, Item Purdical Extrainmenty or other traumatic event, Item Purdical Extrainments

permit. Page Department of Importent: If eny injury or once.

Physician /Medical

Baltimore, Maryland 21215-0036

Funeral Director

Be Completed by

death with the Maryland

Examiner Physician/Medical Be Certification:

Hospitel or Attending after death. within 24 hours a To the Funerel D

25. Was case referred to medical examiner?

29a. Certifier (Check only one)

5 Pending investigation 1 Natural 2 Accident 6 □ Could not be 3 ☐ Suicide determined 4 | Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of

1 Tyes

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

who completed cause of death (Item 23a) (Type, Print)

Rd Chestertmin MD 21620

29d. Date signed (Month, Day, Year) 2006

ms State

Registrar

3

the

31. Date filed (Month, Day, Year)

32. Register's Signature

DEC 1 2 2006

			For State	State of Marylar	-	artment of F		d Mental Hy	2	006	1. 1	200
			Registrar 1. Decedent's Name (First, Middle, Last)			uncate or	Dealli	2. Date of De	Reg. No. C	000	3. Time of	Death Death
	Physici		A 1	Arnold				Month 12	Day	Year	1411	
	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of De		4c. Cou	ZOOG unty of Death	7 717	
	Examin	er	Coastal Hospice	+ the Lake		Salish	day		W	come	00	
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 H		th Vone		ace (State of	r Foreign
	Director		283-20-2270	м 2XF 85	Yrs.	Months Days	Hours M	in. (Month, Da April 2				
	D .		Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo			T			Od. Inside Cit	
	ours after death with the Marylan ral', or Iteme 23a or 28a-f ehow Examitier must be notified at	ž	Toa. State Too. County			Callon				["	1 K Yes	
	Ne M	Director	Maryland Wicomico	Sai	isbury	101 7:- 0-4-			10n Citinan	of What Coun		
	with t			B : ! B	. "110	10f. Zip Code				or what Coun	uy r	
	eath re 23	erai	The Village at Hab	Or POINT ROOM 12. Was Decedent Ever in U		21801	lispanic Origin?	(Specify Yes or No	USA	Race - Americ	an Indian	
40	ter d	Funeral	1 Never Married 2 Married	Armed Forces?		f Yes, specify Cubi	an, Mexican, Pu	erto Rican, etc.)		Black, White,		
336	al', or	þ	3 X Widowed 4 □ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Nav	v	1 ☐ Yes 2 💆 No	Specify:		Spe	ecify: Whi	te	
5-0036	72 hours after death with the Maryland natural; or Iteme 23a or 28a-f ehow oreal Examinational be notified at	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation		16b. Kind o	of Business/Ind		
218	within 7 ene. than "r	g	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	kind of work done DO NOT use retired	d) most of v	working				
2121	filed wil Hygien ather th	6	12	3	Finan	cial Cle	ck		Telep	hone Co	mpany	
pu	d oth	Be	17. Father's Name (First, Middle, Last)					lame (First, Middle		name)		
yla	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the Mental to the Mental transfer the Mental	၉	Arthur Schumann					a Popschi				
Maryland	s 1 and 2 should be filed within 72 ho I Health and Mental Hygiene. Item 27 is marked other than "naturother traumatic event, Ita Maciral	1 5	19a. Informant's Name/Relationship (Ty					Rural Route Numb	200.200			
	1 and Health em 27 ther tr		Linda DiGiovanna/Da 20a. Method of Disposition					arsonsbur Date		Jana 21 on - City or To		
פֿר	0 0		1 Burial 2 X Cremation 3 F	iemovai nom State		sition (Name of matory or other place		17.106				3
Baltimore,		1	4 Donation 5 Other (Specify) 21. Sign fire of Funeral Service Licens			Cremato		/7/06		oury,Ma	гутапо	
Ba	permit. Depertr Importa eny inju		I multo	20 low	H 5	olloway H Ol Snow H	uneral Hill Rd.	Home P.A Salisbu	rv,Mar	yland 2	21804	
			23a. Part 1 Enter the disease, or complete shock, or heart failure. List only or	ications that caused the dea				liac or respiratory a			Approximate Interval Bety	een
	Physician		Immediate Cause (Final disease or condition	Asorrati	on	Preun	non 10				Onset and E	
1	/Medical		resulting in death)	Due to (or as a conse		1 1 00	0.11					
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	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):							
	and and I-tran	Examiner		Due to (or as a conse	nuence of):							
8760,	law requires that the death certificate be executed as been signed by the ettending physicien and 2 should be detached for use as the burial-transit			540 to (or 43 4 00/130)	quonco ory.							
687	phys phys s the	Physician/Medical		1					-			
	leath certifica ettending ph i for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. ff yes, outcome of pregn	ancy				23d	Date of delive	CV.	
Вох	etter i for u	ciar	in the past 12 pronths?	1 Live birth 2 Fet. 4 Pregnant at time of		Ectopic pregnancy Other (specify)	y 		200.		•	ear ear
P.O.	that the de ned by the e detached f	hysi	9 □ Unknown	9□ Unknown								
	igned to be det	by P	Part If. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	obacco use	contribute to th	e cause of de	eath?
Records,	w require been sig should b	edt						10	Yes 2 N	o 3 ☐ Proba	ably 4 □U	nknown
O O	aw requis been 2 should	piet						24a. Was		4b. Were autop	sy findings a	available
Ä	The lav	Completed				-		perfe	2 Z No	death?	22 No	1430 01
Vital	Physician: T this certificat ral director, pa	Be (25. Was case referred to medical examiner?				26. Place of E	Death (Check only	one)		<i>t</i>	
of V	Physic this ca	၉	1 Yes SONO	The state of the s	ER/Outpatier		4 🗀 Nursing	g Home 5 ☐ Resi)	
	ding P h. After t funera	on:	27. Magner of Death Natural 5 ☐ Pending	28a. Vate of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury oc	curred		
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		<u> </u>		Yes 2□No	004 4				
Division	l or Attende efter deatl Director: I in by the	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Spec	ify)	eet, factory, office		28f. Location (City or To	wn, State)	imber or Hurai	HOUTE NUM!	jer,
	To the Hospital or Attending Physician: The within 24 hours eller death. To the Funeral Director: After this certificate h, To the Funeral Director, After this page?	ledicai C	29a. Certifier Certifying Phy (Check only one)	sicien: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or in	n occurred at the tw vestigation, in my o	me, date and pla opinion, death o	ace, and due to the courred at the time,	cause(s) and date and plac	I manner as st ce, and due to	ated. the cause(s))
	o the	Me	29b. Signature and title of certifier	000	A	29c. Licens	se number		29d. Date sig	gned (Month, L	Day, Year)	
	Que		9008	CS N	110	D	262	78	12	-7-	06	
,	8.6		30. Name and address of person who co	empleted cause of death (Ite	т 23а) (Туре,	Print)	4	, ,	10		218	
_	10/1		David E. Coudl	M) (basta	HOSP.	in po.	BOX 17	33 Sa	holen	MD	218	02-
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	9 4 -	•		(3		
	Registr	ar	DEC 0 8 20	106 Bluer	D. A	DEREL			_	-		

		5	State of Maryland	d / Departn		lealth and N			Ecgibic.	
	•	1 - For State Registrar	,		cate of L		,	Reg. No.	006	41281
		1. Decedent's Name (First, Middle, La	,		-		2. Date of De	aath Day	Year	3. Time of Death
Physici /Medic		NGICISA	AlVAREZ				Decembe		2006	6:43 PM M
Examin		4a. Facility Name (If not institution, given	e street and number)	4b.	City, Town, or	Location of Death		4c.	County of Deat	th
		Wicomico Nursing Hom 5. Social Security Number 6.	e Sex 7. Age (In yrs. I		alisbury Under 1 Year	If Under 24 Hrs.	8. Date of Bi		icomico	thplace (State or Foreign
Funeral Director			1 M 2 K F		nths Days	Hours Min.	(Month, D	ay, Year)	D. Co	ountry)
P.	}	Usual Residence of Decedent				1			490	718 / 100
anylau show	5	10a. State 10b. County	1	/, Town or Locatio	1					10d. Inside City Limits 1 ☐ Yes No
the M	ecto	MD WICK	nico y	uant,	Of. Zip Code			10a Citi	zen of What Co	
3a or	I DI	6072 Catch.	Penny Rd		2185	6		//	CA	, and y
death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?			ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or N	0-	4. Race - Ame	
or its	y Fu	1 Never Married 2 Married	1 Yes 2 No		res 2□No	Specify:	rican, etc.)		Black, Whit	1 0 .
il K I 3-0030 within 72 hours after death with the Maryland ene. than "netural", or items 23e or 28e-f show than heter from the mailled at	ed by	3√ Widowed 4 □ Divorced	Year or Dates:	16a. Decedent's				1 10h K	74 e	to Lican
in 72 in 72 n "nat	olete	15. Decedent's E (Specify only highest gr	ade completed)	(Give kind life. DO N	of work done o IOT use retired	ation during most of worl f)	king	160. KI	nd of Business/	rindustry
d with giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Hon	se W	IFE			N/A	
ING KIK 19-0050 be filed within 72 hours after death with the Marylar lat Hygiene. id other than "natural; or itams 23a or 28a-1 show event, the Madical Examiner must be natified at	Bec	17. Father's Name (First, Middle, Las				18. Mother's Nam				21
aryiar should be nd Menta marked umatic ev	ဂ္	Oglestin	Alvarer							Alverer
TOCE, Maryle ges 1 and 2 should to f Health and Mer if item 27 is marks or other traumatic		19a. Informant's Name/Relationship	(Type, Print)	,		and Number or Rui				
s 1 and of Healt item 2		05 Car DIAZ 20a. Method of Disposition	- 3 0 AU 20b. P	lace of Disposition emetery, cremator	(Name of	Penny	Date	20c. Lo	cation - City or	Town, State
Pages nent of i		1 X Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special	Removal from State	emetery, cremator	ry or other plac	12/	11/06			
보 교육관금 .		21. Signature of Funeral Service Lice	insee ()	22. Na	me and Addres	ss of Facility	ennie.	5mm	5 Fun	and Harte
Dermi Depa impo		Misalla	Kninds	917	WIS	bellest.	. Salis	bury	md.	21801
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death yone cause on each line.	n. Do not enter the	e mode of dyin					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a ASCVD							Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequ							
	آء ا	Sequentially list conditions, if any, leading to immediate saute. Fater Incertying	b. DIABETES Due to (or as a consequ	MCLLI"	rus,					
uted d ansit	Examiner	Cause (Disease or injury that initiated events	· HYPERTEN	1CION						
ate be executed hysiclan and the burial-transit		resulting in death) Last	Due to (or as a consequ							
ecords, P.O. BOX 68/60, law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dicai		d						_	
GOLGS, P.O. BOX OR wrequires that the death certificate been signed by the attending prishould be detached for use as it.	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	ncv					Date of del	li
BOX leath cer attendir for use	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ecto	opic pregnancy ner (specify)	,		- 4	3d. Date of del Month	Day Year
the dot	hysi	9 Unknown	9 Unknown		(-,,/					
S, T	by P	Part II. Other significant conditions		ulting in the under	ying cause give	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
KOTGS, wrequires t been signe should be o	ted	MALNOURISHME	NT.				10	Yes 2	□No 3□Pr	robably 4 Inknown
lawr lawr las be	Completed						24a. Was	psy	prior to	utopsy findings available completion of cause of
VITAI HEC sician: The law certificate has b irector, page 2 s	Con						pert 1 ☐ Yes	ormed? 2 No	death? 1 ☐ Yes	2 □ No
OT VICAL Physician: 7 This certifica	Be	25. Was case referred to medical examiner?	Hospital:		Otho	26. Place of Dea				-
Phy rthis	: To	1 ☐ Yes V☐ No 27. Manne-of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of	28c. Injun	er: Wursing H	ome 5 ☐ Res 28d. Describe			cify)
VISION OT Attsnding Phy r death. sctor: After thi by the funeral of	atior	Natural 5 Pending 2 Accident investigation		Inju <i>r</i> y		k? Yes 2 □ No				
INISION or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street,	factory, office		28f. Location City or To	(Street and	d Number or Ri	ural Route Number,
pital or ours afte eral Dir filled in	Cer					,				
UNISION HOSPITAI or Attendin 24 hours after death. Funeral Director: Att	edical	29a. Certifier Certifying P (Check only 2 Medical Exa	hysician: To the best of my knowniner: On the basis of examination	wledge, death occ tion and/or investi	curred at the tin gation, in my o	ne, date and place, pinion, death occu	and due to the rred at the time	cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)
To the Hosi within 24 ho To the Fund completely f	Med	29b. Signature and title of certifier	and manner stated.		29c. License			29d. Dat	e signed (Mont	h, Day, Year)
V V		· Mo-11			000	63199.		12/	8/20	06
~ Year		30. Name a dre s of person who	completed cause of death (Item	n 23a) (Type, Print					1	
			614 Easternshore [ury MD 2	21804				
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa							
Regist	ar	DEC 0 8	2006 Bleeve	H. Spe	Ke)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Amend #20b Per 1. Decedent's Name (First, Middle, Las					2. Date of Dea	Reg. No.)6	3. Time of Deam
3	Physici		COLONEL	BARI	NES			Month DECEMBE	Day 2R 10 2	Year 2006	10:00 A ^M
-	/Medic Examir		4a. Facility Name (If not institution, give 2423 VALLEY WAY	street and number)		4b. City, Town, o	r Location of Death		4c. County	of Death	
F	Funeral Director		238-68-8325				If Under 24 Hrs. Hours Min.		v, Year)	Cou	
	he Maryland 8a-f show cuiffed at	ector	Usual Residence of Decedent 10a. State 10b. County MD PRINCE (City, Town or L	VERLY					1 X Yes 2 □ No
	With t	i Dir	10e. Street and Number 2423 VALLEY WAY			10f. Zip Code 2078	35				intry?
036	within 72 hours after death with the Maryland ane. than "naturei", or itema 23a or 28a-f show na Madical Exeminar mast be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 □ No A If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2⊠ No	lispanic Origin? (Si an, Mexican, Puerti Specify:	pecify Yes or No- o Rican, etc.)		ck, White,	, etc.
2 0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece (Give	edent's Usual Occup a kind of work done DO NOT use retired	ation during most of wor	king	16b. Kind of B	usiness/Ir	ndustry
21215-0036	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired CLERK	1) = -		PRIVA	TE	
<u>д</u>	ified Hygi other	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle.	Maiden Suman	ne)	
ylar	Menta Menta mrked mrked	To B	SOLLY BARNE	S			MADESS	IE CLAR	10g. Citizen of What Country 10g. Citizen of What Country U.S.A. 10g. Citizen of What Country U.S.A. 14. Race - American Indian, Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry PRIVATE 16ddle, Maiden Sumame LARK 1mber, City or Town, State, Zip Code ARYLAND 20785 20c. Location - City or Town, State 5. GOLDSBORO, NORTH CAROLI ENKINS FUNERAL HOME DOVER, MARYLAND 20785 Dry arrest. Approximate Interval Batween Onset and Death Did tobacco use contribute to the cause of death? 1		
Maryland	12 sho h and 7 is m	8	19a. Informant's Name/Relationship (7						Number, City or Town, State, Zip Code)		
<u>6</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturei", or itema 23a or 28a-f show any injury or other traumatic event, the Modical Examiner mast be notified at ance.		ROBERTA BARNES/WI 20a. Method of Disposition	20b	. Place of Disp	osition (Name of		Date	own, State		
Baltimore,											HOME
	go E a d		23a Part 1 Enter the disease or come	chall						LAND	
	Physician /Medical Examiner	lner	23a. Part1. Enter the disease, or compshock, or heart faiture. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Adenocarcin Due to (or as a cons Due to (or as a cons	noma of equence of): Colon	Colon					
68760,	rificate be executed og physicien and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	equence of):						
P.O. Box (To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								
rds, P	quires that in signed b uld be deta	þ	Part II. Other significant conditions of Stroke	ontributing to death but not r	resulting in the u	underlying cause giv	en in Part I.		_		
al Records,	: The law re cate has bee ; page 2 sho	Completed						perfo	rmed?	prior to co death?	ompletion of cause of
₹	sician certif rector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ∑No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	ent 3 DOA Oth	or.	th (Check only o		(Case	4.1
1 0	g Phy er this seral d	n: To	27. Manner of Death	28a. Oate of Injury (Month, Day Year)							<i>'y</i>)
Sio	Attending ir death. ector: Alter by the fune	atlo	1 Natural 5 Pending 2 Accident investigation	1	injury		Yes 2 □No				
Division of Vital	after d after d Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, si ecify)	treet, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	t and Number or Rural Route Number, tate)	
	the Hospital thin 24 hours a the Funeral t mpletely filled	Medical C	29a. Certifier (Check only one) 1 ☑ Certifying Ph 2 ☐ Medical Exam	ysician: To the best of my k niner: On the basis of exam- and manner stated.	knowledge, dea ination and/or in	th occurred at the tir nvestigation, in my o	me, date and place pinion, death occu	, and due to the orred at the time,	cause(s) and madate and place,	anner as s	stated. to the cause(s)
)	To the vithin To the comple	M	29b. Signature and title of certifier	m	2	29c. Licens	-	59633	29d. Date signe	d (Month,	Day, Year)
R	(10)		GLEX JACOL/	completed cause of death (IIII) M.D. 1221 MEH	RCANTIL	E LANE UP			YLAND 2	0774	
*	Sta Regist		3y. Date filed (Month, Day, Year) DEC 1 2 2006	32. Registrar's Sig	per	d					

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3:10 PM **Physician** Mae Brown December 4, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Fort Washington Hospital Fort Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🔀 F 459-34-6689 85 January 11, 1921 W. Virginia Director Usual Residence of Decedent 10d. Inside City Limits deeth with the Maryland 10c. City. Town or Location 10a. State 10b. County rai', or items 23a or 28a-f ahow Examiner rust be notified at 1 XYes 2 □ No Prince George's MD Oxon Hill Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20745 U.S. 5429 Danby Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African-American 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Introportent: if item 27 is marked other than "natural", or ite importent: if item 27 is marked other than "natural", or ite any injury or other treumatic avent, the Medical Examina once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. þ 3 DWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Maid Domestic 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Jackson Flossie Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5429 Danby Avenue, Oxon Hill, MD 20745 Grace Chatmon-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 12-15-06 Beckley, West Virginia Greenwood Memorial Park * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bonnette & Assoc. Funeral Home 21. Signature of Funeral Service Licensee 2504 28th St., N.E., WDC 20018 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Belween Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 24hr Gangrene of both legs /Medical Due to (or as a consequence of): **Examiner** 24hr Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit 5yr Type 2 NIDDM Due to (or as a consequence of): been signed by the attending physicien should be detached for use as the buria Division of Vital Records, P.O. Box 68760, Peripheral Adrenal Disease 6 mos. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2X No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? certificate 1 Yes 20 No 1 Yes 2 No Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2X No 2 SER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire 0 the Hospital 1 Gretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 Old Branch Ave., Ste.C101, Clinton, MD 20735 Laxmi Berwa MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 08 2006 Registrar

			For State Registrar	State of Maryl			nt of H		and Me		ene	006	1.1201.
· 6 .	6 . 82		Decedent's Name (First, Middle, Last)						- 4	2. Date of Death	frame	U U O -	3. Time of Death
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	/Medic		4a. Facility Name (If not institution, give s			4b. City	, Town, or	Location o		occember.		county of Death	
-3	Examin	ier	7110 Decatur Stre				attsv					ince Ge	
	F		5. Social Security Number 6. Sex		rs. last birthday) If Unde	er 1 Year	If Under 2		3. Date of Birth			place (State or Foreign intry)
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	yland		10a. State 10b. County		City, Town or L								10d. Inside City Limits
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	r 28	Funeral Director	10e. Street and Number			10f. Z	ip Code			100	g. Citize	en of What Cou	intry?
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	dead	ner	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Deci	edent of Hi	spanic Orig	gin? (Spec	rfy Yes or No-	14	4. Race - Amer Black, White	
9	or its	F	1X Never Married 2 ☐ Married	1 ☐ Yes 2x No If Yes, Give		1 Yes		Specify:	.,	30.7			lack
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<u>¥</u>		ပ္	Sam Battle							lffith			
Maryland	2 S		19a. Informant's Name/Relationship (Ty Janice L. Nicholas							Route Number, (S ville,	-	20784	p Code)
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Baltimore,	o 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	emoval nom State	b. Place of Disp cemetery, cre				12/9/	'06			
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Sall	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licens	10.N						Lincol			
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Box	eath certific attending p	Z	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre							23	3d. Date of deli-	very
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Ö		Certification:	4 Homicide determined	building, etc. (Sp	outy)					City or Town,	Jia(8)		
	pspit hours unere		29a. Certifier 15 Certifying Phy	sician: To the best of my	knowledge, dea	ath occurre	d at the tim	ne, date an	d place, a	nd due to the cau	use(s) a	and manner as	stated.
	To the Hospitel of within 24 hours after the Funerel Discompletely filled in	edicai	(Check only 2 Medical Exami	ner: On the basis of exar and many stated.	milation and/or i	rivestigatio	лі, іп my of	Jimon, dea	ui occurre				
	with To t	Σ	29b. Signature and titl of certifier	(/	1	2	9c. License		1.			signed (Month	
	Λ.		100		19		1)4	150	00		12	/- C	, ,
	6)		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type	Print)	1. 17	111	R	ocie)	MO	retts
	5		14 200, 6/4	COMIT	+-EX	CI	// /		ر۲	00-16			
		ate rar	31. Det offed (Month, Day, Year)	32. Registrar's S	ignature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician PAULINE **JEAN** POSTELL MARTIN DECEMBER 7, BOYD 2006 12:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CASEY HOUSE MONTGOMERY HOSPICE ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** JANUARY 25, 1927 577-46-4107 1 □ M 2 🖾 F 79 Director PENNSYLVANIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 'natural', or items 23a or 28a-f shov dical Examiner must be notifled at Director 1 Yes 2 No MARYLAND HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6500 FREETOWN ROAD 21044 Completed by Funeral UNITED STATES OF AMERICA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 🕅 Divorced Specify: BLACK M-dical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ĝ ACCOUNTING TECHNICIAN COUNTY GOVERNMENT permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If item 27 is marked other any injury or other traumatic event, ti 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) RAYMOND MARTIN PAULINE POSTELL ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTOPHER T. BOYD - SON 13137 CLIFTON ROAD; SILVER SPRING, MARYLAND 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State FT. LINCOLN CREMATORY 12/14/06 BRENTWOOD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HINES - RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses Not 11800 NEW HAMPSHIRE AVE, SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE RENAL DISEASE /Medical Due to (or as a consequence of) Examiner RENAL SARCOIDOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed attendeath.
Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burnal-transit director. Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1☐ Yes 2XI No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 1 ☐ Yes 2 X No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA HOSPICE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XI Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

Division or Vital Records, P.O. Box 68760 To the Hospital o within 24 hours aft To the Funeral Di Registrar

Baltimore, Maryland 21215-0036

29d. Date signed (Month, Day, Year) Musmo 30. Name od address of person who completed cause of death (Item 23a) (Type, Print) CYNTHIA WILLIAMS, DO MONTGOMERY HOSPICE 6001 MUNCASTER MILL RD, ROCKVILLE, MD 20852 31. Date filed (Month, Day, Year) 32 Registrar's Signature 2006 11 DEC **ORIGINAL**

State

		1- State of Maryland		artment of H		Mental Hy	giene Reg. No.2	06	41286
Physic /Med Exam	ical	Decedent's Name (First, Middle, Last) Robert Elon Baker, Jr. Aa. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Dea		er 10,	2006 ty of Death	3. Time of Death 10:41 AM
Funera Director		233 21 0,30	ast birthday) 30 Yrs.	Rockvill If Under 1 Year Months Days	e If Under 24 Hr Hours Mir		Montg		place (State or Foreign ntry)
Dallilliore, Mid yidlia 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	Maryland Montgomery Gait 10e. Street and Number 217 Booth Street #111A 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced Year or Dates 1944 – 4 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)	16a. Deced	10f. Zip Code 20878 Was Decedent of Hilf Yes, specify Cube 1 Yes 2 No Jent's Usual Occup, kind of work done of DO NOT use retired ar Physic	Specify: ation during most of w t) List 18. Mother's Na	(Specify Yes or No erto Rican, etc.) rorking ame (First, Middle	Spec 16b. Kind of Federa	f What Cour ace - Americ ack, White, ify: Whit Business/Inc	can Indian, etc. te
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	leted by Physician/Med	## FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part ##. Other significant conditions contributing to death but not resure. ### Hypertension, Coronary Artery D:	death 3 = eath 5 = eath 5 = eath = ea	Ectopic pregnancy Other (specify)			tobacco use coi Yes 2 No	ntribute to th 3 Prob	ery Day Year he cause of death? pably 4 □Unknown psy findings available
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the Hospital or Atte hin 24 hours after dei the Funeral Directo mpletely filled in by th	Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At ho building, etc. (Specify Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinat and manner stated.	v) wledge, deatl	n occurred at the tin vestigation, in my o	pinion, death oc	City or To	wn, State) cause(s) and n	manner as st	o the cause(s)
P N P S	2	29b. Signature and title of certifier Gynthia Williams, D.O. 6001 Mun.	23a) (Type, caster	Print)	5803			//- O	-
S' Regis		31. Date filed (Month, Day, Year) GEC 12 2006 32. Figistrar's Signat	br A	back					

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3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Certifier 29g. Certifier	ion	ending path. or: Aft	atio	2 Accident investigation	, Day 1 ear) Inquiy						
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	Divis	i or Att after de Diracte	ertific	determined 256. Place		street, factory, office					
T 4 L 0 one) and manner stated.		Hospital 24 hours a Funeral E inted filled	edical C	(Check only 2 Medical Examiner: On the ba	sis of examination and/or	ath occurred at the time, d investigation, in my opinio	date and place, and due to the on, death occurred at the time	e cause(s) and manner as e, date and place, and due	s stated. e to the cause(s)		
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		within To the comple	Me	<i>(*)</i>		29c. License nur	mber	29d. Date signed (Mont	h, Day, Year)		
024525 12/106)			1 ()	102	4525	12/1	106		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OBIORA OGBUAWA, MD 11701 LIVINGSTON ROAD FORT WASHINGTON, MARYLAND 20744	1	NB5					WASHINGTON,	MARYLAND 2	0744		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DEC 1 1 2006		Che	ate	APP		1					

		•	For State Registrar	State of Mary			it of Health			giene Reg. No 2006	41288
			Decedent's Name (First, Middle, Las	t)					2. Date of Dea	ıth	3. Time of Death
	Physicia		CHRISTIN	A F		BA	RNE	S	Month No.155 m.B	Day Yea	
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City	Town, or Location	on of Death	10000000	4c. County of De	
			CHESTER RIVER	HOSPITA	L CE	VTER			TOWN	KEI	VT
	Funeral		5. Social Security Number 6. S	7. Age (In	yrs. last birtl	Months	r 1 Year If Uni Days Hou	der 24 Hrs. rs Min.	8. Date of Birth Month, Day 10/07/1	9. B	irthplace (State or Foreign Country)
	Director	-	212-30-1319		91 Y	rs.			10/0//1	1915	MD MD
	and w	ŀ	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location					10d. Inside City Limits
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Maryland	d 2 should th and Men 17 is marke traumatic		19a. Informant's Name/Relationship (1 G. RICHARD DEVED			-			OINT, FI	r, City or Town, State	, Zip Code)
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ē	000		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			v, crematory`or V PARK (CEMETERY	12/0	4/2006	BALTIMORE	, MD
altımore,	permit. Pag Depertment Important: I eny injury o once.		21. Signature of Funeral Service Licen			22. Name a	nd Address of Fa	acility			
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Box	eath certific attending p I for use as I	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death	3 □Ectopic p				23d. Date of o	lelivery Day Year
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<u> </u>	Physicia this cer al direct	2	1 Yes 2 No			patient 3 D	OA Other: 4	Nursing Ho	me 5□Resid	lence 6 Other (S	pecify)
ב	ding Ph h. After th funeral	.uo	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. T ear) In		28c. Injury at Work?		28d. Describe h	ow injury occurred	
<u>s</u>	eat or:	cati	2 Accident investigation 3 Suicide 6 Could not be		At home for	M	1 □ Yes 2	2 🗆 No	29f Logation /S	Street and Number or	Pural Pouta Number
Division of Vital	s after of Air Direct	Certification	4 Homicide determined	28e. Place of Injury - building, etc. (S	Specify)	m, street, facto	у, опісе		City or Tow		nulal houle Nullibel,
	To the Hospital or Att within 24 hours after d To the Funerel Direct completely filled in by	Medical (ysician: To the best of m niner: On the basis of exa and manner stated.							
	To the within 2. To the to complet	Me	29b. Signature and title of certifier			29	c. License numb	per	-	29d. Date signed (Mo	nth, Day, Year)
}	11.		11.11.11lum	mD.		1.7	121313	3		12/4/0	10 2620
	7		30. Name and address of person who		(Item 23a) (Type, Print)		a	0.5		
	ms		till KIN	K. WLEN,	415	Wash	year 1	tue,	Chest	Moun, 1	10 2620
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Rosensk					

		•	For State Registrar	State of Ma	-	epartment of Certificate of		Mental Hygie	ne 006	4128	39
	Physici	an	Decedent's Name (First, Middle, L					2. Date of Death Month December	Day Year	3. Time of De 16:08	eath \mathbf{P}^{M}
	/Medic Examin	-	Vernon Gilbert B 4a. Facility Name (If not institution, g			4b. City, Town,	, or Location of Death		4c. County of Death		1
			14272 Backbone R			Eden			Wicomico		
b	Funeral Director			157 M 2□ F	e (In yrs. last birtho 70	Months Day		8. Date of Birth (Month, Day, Ye 12/28/19	25 .	nplace (State or Fountry)	oreign
	D.		228–44–8316 Usual Residence of Decedent					12/20/13	Vir	ginia	
	ehow	2	10a. State 10b. County Marvland Wicomic	0	10c. City, Town of Eden	or Location				10d. Inside City L	
	the M	Directo	Maryland Wicomic	0	Lacii	10f. Zip Code		100	Citizen of What Cor		
	h with		14272 Backbone R	đ.		21822			SA	,	
	eme 2	Funeral	11. Marital Status	12. Was Decedent 1 Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White		
36	filed within 72 hours after death with the Maryland Hygiene. the than "naturel", or iteme 23a or 28a-f ehow ent, the Markical Examiner clust be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 1 If Yes, Give Year or Dates:	40	1 ☐ Yes 2 🛣 N			Specify:		
몽	2 hou	ted t	15. Decedent's	Education	16a. D	ecedent's Usual Occ	upation	168	o. Kind of Business/l	ite	
21215-0036	thin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5	i+}	Give kind of work don fe. DO NOT use retii		4			
7	lled without the the		12 17. Father's Name (First, Middle, La:		Buil	der Contr	_	ne (First, Middle, Mai	nstructio	n	
Maryland		To Be	Harvey Budd	47			Helen C		den Sumame)		
ary	2 should be and Mental I marked o	۲	19a. Informant's Name/Relationship	(Type, Print)	19b. N	Mailing Address (Stree	et and Number or Ru	ral Route Number, C	ity or Town, State, Z	ip Code)	
Ž,	and 2 ealth a n 27 le		Lana Budd/Wife				ne Rd. Ede	en, Maryla	nd 21822		
Baltimore,	Pages 1 ient of H nt: If Ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		cemetery,	isposition (Name of crematory or other page 10 Memoria	12/0		. Location - City or I		
Balti	permit. Pages 1 and Depertment of Healt Important: If Item 2 any Injury or other anges.		21. Signature of Funeral Service Liv	Association CF	SP	22. Name and Add	ress of Facility Funeral Ho	ome P.A. Salisbury,	V ==		
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that caused y one cause on each lin	the death. Do no	t enter the mode of d				Approximate Interval Betwee Onset and Dea	an ath
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of		1 ()	<u> </u>			
	₽ ≅	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of)	:		P-9		-	
	xecute and al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of)	:					
760,	ate be executed thysicien and the burial-transit	ical E		d							
89	ntifica ng ph	Medi	IF FEMALE:								
P.O. Box	Attending Physician: The law requires that the death certificate be executed refath. redath. ector: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	ncy		23d. Date of deli- Month	very Day Yea	ır
	s that med by	by Pt	Part II. Other significant conditions	contributing to death b	ut not resulting in t	ne underlying cause g	given in Part I.	23e. Did tobac	co use contribute to	the cause of deat	DIS.
ğ	w require been sig should b		Diabetes Mi	lleturs				1 🗆 Yes	2 □ No 3 □ Pro	obably 4 🗗 Unki	nown
Division of Vital Records,	e law r has be	Completed						24a. Was an autopsy performed	24b. Were aut prior to c death?	topsy findings ava ompletion of caus	idable se of
a	ician: Th certificate rector, pag		25. Was case referred to medical				OC Place of David	1 ☐ Yes 2 🔀		2 No	
<u>=</u>	ysicia is cert direct	To Be	examiner? 1 \(\text{Yes} 2 \(\text{No} \)	Hospital: 1 ☐ Inpatie	nt 2 ER/Outp	atient 3 DOA	Whos	ith (Check only one) ome 5 ☑ Residence	e 6 □Other (Spec	afy)	
0 0	ding Ph h. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry 28b. Tin y Year) 1nju			28d. Describe how			
Sio	ttendi death. tor: A the fu	cat	2 Accident investigat 3 Suicide 6 Could not	he	A h		☐ Yes 2 ☐ No	096	t and Number or Ru		
<u>></u>	ital or A	Certification:	4 Homicide determine	d building, etc	c. (Specify)	n, street, factory, office	9	City or Town, S		rai noble Nulliber	
	To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of and manner sta	examination and/	or investigation, in my	opinion, death occu	rred at the time, date	and place, and due	to the cause(s)	
)	or With	Σ	29b. Signature and title of certifier	- mn			154127	29d.	iz/ob/		
(Ba		30. Name and address of person wh	o completed cause of d	eath (Item 23a) (T		11				
	D~		31. Date filed (Month, Day, Year)	100 F	over	st. Sa	lish	mo z	1804		
	Sta Registr		DEC 0 8	2006 32. Hegistra	ar's Signature	1	1				
DH	MH 17 Rev 1/2			Jacob Contract of the Contract	Kes SU.	MORNEY)					

ORIGINAL

06-09621 Frankie B Brown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	tate of Wal yland /	•	ate of Death			Reg. No. 201	15 1.129
Physicia Medical Examir	n/	1. Decedent's Name (First, Mide			Brown		. 2. Date of D Month	Day Year Der 17, 2006	3 Time of Death 7
Wieurcai Examin	ie.	Frankie 4a. Facility Name (if not instituti	B. on, give street and number)		4b. City, Town	, or Location		4c. County of Dea	
		7235 Sunnyside Land			Parsonst	ourg		Wicomico	
Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last bi		ear If Unde			Birthplace (State or eign
Director		220-68-8471	1 X M 2 F	51_	Yrs.	Jays Hours	12-1		Country) MD
ž.		Usual Residence of Decedent 10a. State 10b. County		10c. City. Towi	n or Location				10d Inside City Limits
d Fe Fe			mico	Darco	nsburg				1 Yes 2 X No
arylan 8a-f sl	Director	10e. Street and Number	mirco	18130	10f. Zip Cod	е		10g. Citizen of What Co	ountry?
the Ma or 2	Dire	7235 Sunnysid	e Lane		2184	9		USA	
n with	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of		gin? (Specify Yes or n, Puerto Rican, etc.)	No- 14. Race - Am White, etc.	erican Indian, Black,
or ite	Fun	1 Never Married 2 N	1 Yes 2	X No	1 Yes 2 X			Specify: W	hite
irs afte	à	3 Widowed 4 X D	vorced If Yes, Give Year or Dates: ecify only highest grade com	pleted) 16a	Decedent's Usual Occu			16b. Kind of Busines	
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5	+)	during most of working	life. DO NOT	use retired)		
036 vithin ene er tha	E I	12			Bus Drive				chool System
15-C filed v Hygi d oth		17. Father's Name (First, Middle				10.0		e, Maiden Surname)	
21215-0036 ould be filled within 7 Mental Hygiene marked other than ic event, the Medica	o Be	Gorman Thomas 19a. Informant's Name/Relation		11	9b. Mailing Address (S		el Willard mber or Rural Route!	Number, City or Town, Sta	ate, Zip Code)
MD d 2 sho Ith and n 27 is		Julie Banks -	daughter		32956 <u>Gadwa</u>	ıll Lar	ne, Parson	sburg, MD 2	
1 5 8 2 2		20a Method of Disposition 1 X Burial 2 Crematic	n 3 Removal from Sta		of Disposition (Name of atory or other place)	cemetery,	Date	20c. Location - City	or Town, State
Baltimore, permit Pages 1 a Department of He Important: If ittering injury or other t		4 Donation 5 Other	Specify:	1	salem Ceme	tery	12-21-200	06 Parsonsb	urg, MD
Salt ermit Departi mport njury		21. Signature of Funeral Service	e Licensee					uneral Home	2100/
Physician		23g. Part I. Enter the disease	complications that caused	the death. Do r	1 / U5 E. Monot enter the mode of dy	laın St ing, such as d	cardiac or respiratory	isbury, MD arrest, shock, or heart	Approximate Interval
/Medical		failure. List only one paus Immediate Cause (Final diseas	e on each line.						Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conse		71 HILOXICATO				
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b	quence of):					
	Examiner	cause. Enter Underlying Caus (Disease or injury that initiated	C		·				
red	Exa	events resulting in death) Last	Due to (or as a conse	quence of):					
760, foate be executed physician and the burial - transit	ical	X UNPENDED		27 290-	-f, perME, g86	3 1/2/0	7 יויי 7		
760, icate be physici the bun	Medical	IF FEMALE:	23c. If yes, outcom					23d Date of deliv	ery
687 certific nding p	sician/	23b. Was decedent pregnant in past 12 months?	ENG BING	time of death	2 Fetal death 5 Other (Specify)	3 Ectopi	ic pregnancy	Month	Day Year
Box 68 e death certiff the attending ed for use as t	ıysic	1 Yes 2 No 9 U	nknown 9 Unknown		5 Other (Specify)				
tal Records, P.O. Box 68' cian: The law requires that the death certificate certificate has been signed by the attending	y Phy	Part II. Other significant cond	itions contributing to death	but not result	ng in the underlying cau	se given in P		d tobacco use contribute	
S, P	ed by							Yes 2 No 3 ✓ P	
ord: w requas bee	plet								autopsy findings available o completion of cause of ?
Rec The la icate h	Completed						1 🗸 Ye	es 2 No 1	
Division of Vital Records, P.O ral or attending Physician: The law requires that the safer death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaxed.	Be	25. Was case referred to medic examiner?	Hospital: 1 Inpatie	nt 2 FR/	26.P Outpatient 3 DOA	Other	(Check only one) Nursing Home 5	Residence 6 ✔ Ot	her Scene
of Viiing Physi	₽:	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28b		Injury at Wor		be how injury occurred	
OD C ending ath. or: Af	tion		nding Fnd 12/1		nd 7:33 am	Yes 2	No unknow	n	
ivisior I or Attend after death. Director:	ifica	2 Accident Inv 3 Suicide 6 X Co	28e Place of In		farm, street, factory, offi	ce building, e	etc. 28f. Location	on (Street and Number or	Rural Route Number, City yside Lane
Di Hospital of 24 hours a Funeral I	Certification:	4 Homicide de		residence	-		Parson	sburg, MD	
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier (Check only one) Certifying	Physician: To the best of magnification and the basis of examiner: On the basis of examiners.	y knowledge, d mination and/o	eath occurred at the time r investigation, in my opi	e, date and pl nion, death o	lace, and due to the o ccurred at the time, d	cause(s) and manner as s ate and place, and due to	tated. the cause(s)
To the within 2 To the Complet	Medical	29b. Signature and title of certi	and manner stated.			cense number		29d Date signed (I	
W.		-12. n.h.	Meal o	Lm	0	.C.M.E.		December 18,	2006
000		30. Name and address of person		eath (Item 23a)				
-7		Tasha Greenberg M	D. Assistant Medica	al Examine	r 111 Penn Stre	et, Baltimo	ore, MD 21201		
S Regis	tate	31. Date filed (Month, Day, Yea	0 2006 32. Registra	r's Signature	Sperk				
- Drivin 17 Rev 172			Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan		RIGINAL				
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		•	For State	State of M	•	epartment of Certificate of		d Mental Hy	giene Reg. No 2	106	41291
			Registrar 1. Decedent's Name (First, Middle,	Last)		orimodio o		2. Date of De	ath	000	3. Time of Death
	Physicia		DUANE W. VAN	BERGEN				Month /2	04	2006	2058P-M
	/Medic Examin		4a. Facility Name (If not institution,	give street and number;)	4b. City, Town,	or Location of D	Death	4c. Cou	nty of Death	
			Peninsula Regio	nal Medica	al Center	Salis			Wie	omico	
	Funeral Director		5. Social Security Number 309-42-0312	7. Ag	ge (In yrs. last birthd	Months Day		Min. B. Date of Bir Month DEC 2 I	1 th 1 ⁷ 9 ² 40	9. Birthp	lace (State or Foreign
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				1	Od. Inside City Limits
	Maryli f sho	ō	DELAWARE SUSSE	x	MILFOR	KD.					1 ☐ Yes 2√ No
	the P	Director	10e. Street and Number			10f. Zip Code)		10g. Citizen	of What Coun	itry?
	3a or		17109 TURTLE HI	LL ROAD		19963	3		USA		
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I feel and 18 see a second the material show other treumstic event, the Medical Examinar must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin Iban, Mexican, P	? (Specify Yes or No Puerto Rican, etc.))- 14. F	Race - Americ Black, White,	etc.
21215-0036	urs aft	É	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 → Yes 2 ☐ If Yes, Give Year or Dates:	[№] 1963–1967	1 ☐ Yes 2 N	o Specify:		Spe	cify: WHIT	ľE
Ö	72 ho	Completed	15. Decedent's (Specify only highest	Education	16a. D	ecedent's Usual Occ	upation	f working	16b. Kind <i>o</i>	f Business/Inc	dustry
7	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	e. DO NOT use reti	red)	, working			
N	filed w Hygier other th	S	47 Fathada Nama (First Middle)	2	RES	SEARCH ANA	T	Nama (Sint Middle			ERNMENT
Maryland	id be fi	To Be	17. Father's Name (First, Middle, La WILLIAM VAN B				MONA	Name (First, Middle SCHMIDT	, маюеп Бип	iame)	
ary	should be ind Mental is marked o	-	19a. Informant's Name/Relationshi		19b. M	lailing Address (Stre		or Rural Route Numb	er, City or To	wn, State, Zip	Code)
Ž	and 2 lealth a m 27 le		MARY L. VAN BERG	EN /WIFE	171	09 TURTLE	HILL R	OAD, MILF	ORD, DE	19963	
Baltimore,	permit. Pages 1 an Depertment of Heal Important: if item 2 eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		,	isposition (Name of crematory or other p		Date /00 /06		on - City or To	
3altir	permit. F Depertme Importer eny injur	l	21. Signature of Funeral Service Li		ASIEM S			HOMES & C		DELAWAR RIUM	UL.
	403 e d		23a. Part1. Enter the disease, or	atsy	od the death. De not			WAY, LEWE		19958	Approximate
	Physician /Medical		shock, of heart failure. List of Immediate Cause (Final disease or condition resulting in death)	aa.	s a consequence of)	irachn	old	Bleed	7		Interval Between Onset and Death
	Examiner	1	Sequentially list conditions,	b	s a consequence of)						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence or						
ő,	ate be executed hysicien and the burial-transit	I Exa	resulting in death) Last	C. Due to (or as	s a consequence of)						
8760,	icate b physic s the b	dlcal		d		·			·		
O. Box 6	The law requires that the death certificate be executed are hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 ☐ Fetal death at time of death	3 □Ectopic pregnar 5 □ Other (specify)	ncy		23d.	Date of delive Month	ory Day Year
P.O.	signed by d be deta		Part II. Other significant condition	s contributing to death	but not resulting in th	e underlying eause	given in Part I.	23e. Did	tobacco use c	ontnbute to th	ne cause of death?
rds	w requires been sign should be	ed by	peripher	al Vu	Scular	- dis	ease	10	es 2 □ No	3 ☐ Prob	ably 4 ∐Unknown
Records,	he law re e hes bee age 2 sho	Completed	1						psy prmed3	prior to cor death?	psy findings available inpletion of cause of
<u>ra</u>	Physician: The this certificate he al director, page	0	25. Was case referred to medical				26. Place of	1 ☐ Yes Death Check only	2 A No	1 🗆 Yes	2□ No
<u> </u>	Physici this cer al direc	10 B	examiner? 1 ☐ Yes 2X No	Hospital: 1 X Inpati	ient 2 🗋 ER/Outpa	atient 3 DOA	Other: 4 🗀 Nursi	ng Home 5 ☐ Res	idence 6 🗀	Other (Specify	r)
0			27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Da	jury 28b. Tim ay Year) Inju		jury at fork?	28d. Describe	how injury oc	curred	
Sio	endite eath. or: Al	catic	2 Accident investiga				∐Yes 2 No				
É	i or Atl after d Direct in by	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Place of it	njury - At home, farm etc. <i>(Specify)</i>	, street, factory, offic	9		Street and Nu wn, State)	imber or Rura	il Route Number,
	Hospita 4 hours Funeral 1ely fillec	edical C	29a. Certifier Check only one) Certifying	Physicien: To the besi xeminer: On the basis and manner s	of examination and/o	death occurred at the	time, date and p y opinion, death	place, and due to the occurred at the time,	cause(s) and date and place	manner as si	ated. the cause(s)
	within 2	Me	29b. Signature and title o certifier			29c. Lice	nse number		29d. Date sig	ned (Month,	Day, Year)
	11/			1			_		. 1	1 - 1	
						DE	55658		10	1 110	2006
•	120		30. Name and address of person w	no completed cause of	death (Item 23a) (Ty			ISBURY	ノウ, Md.	יפוב)-006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December **Physician** Marian Virginia Burkins 2006 18. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital
5. Social Socurity Number 6. Sox 7. Havre de Grace Harford 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Funeral 1□M 2**%**□F Maryland 79 Director August 5. 220-22-4036 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir then "naturel", or itema 23a or 28a-f show the Medical Exeminar must be notified at 1 ☐ Yes 2 No Completed by Funeral Director MD Havre de Grace Harkord 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code u.s.A. 47 Telestar Way 21078 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Operator <u>Telephone Company</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Heelth and Mental Beulah Fogleman Roman Ragan ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Heelth item 27 i Lawrence W. Burkins (husband) 47 Telestar Way, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Depertment of H
Important: if its
eny injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gardens 12/22/2006 Aberdeen, Maryland 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 21. Signature of Funeral Service Licensee 123 South Washington St, Havre de Grace, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

22 DAYS Immediate Cause (Final disease or condition resulting in death) ACUTE PANCREATITIS Physician /Medical Due to (or as a consequence of) Examiner S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) sete has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ٥ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 22 No 1 ☐ Yes 2 ☐ No this certificete 1 ☐ Yes 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: within 24 hours effect death.

To the Funerel Director: Afte completely filled in hours. 1 Natural 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

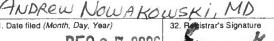
Vital o Division

Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



The Nonalinns 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

125 N. MAIN ST Bel AIR, MD. 21014

29c. License number D09086

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3:15PM December 7 2006 Shirley Lou Clute /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Renaissance Gardens Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Yrs. 214-30-2183 June 7, Missouri Director 73 Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at M☐Yes 2 ☐ No Director Maryland Prince George's Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20770 114 Lynbrook Court USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Caucasian Specify: Completed by 3 ☑ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Kiplinger College (1-4or 5+) Elementary/Secondary (0-12) Word Processor Publishing other treumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: If Item 27 is marked oth any injury or other treumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Allen Morrison Alta Beall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1574 Loring Court, Severn, MD Patricia L. King - Daughter 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2

Cremation 3

Removal from State Fort Lincoln Cemetery Dec. 11, 2006 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. MO1343 4739 Baltimore Ave., Hyattsville, MD 20781 allued from 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroschrotic cardiovascular discase Physician /Medical Examiner Gall bladder cancer with liver history of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consquence of): Examiner and I-transit Memory The law requires that the death certificate be executed 1055 Due to (or as a consequence of): burial-Pnumonia Physician/Medical phys the L as use IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Year for Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? page this certificate 1 Yes 2₺ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 1 ☐ Yes 2 ☐ No ē 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending Injury 1 Matural 5 Pending 1 Tes 2 No death. investigation 2 Accident the hours after deat unerei Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerei L Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 059524 Dicember 8 2006 nnana MD Lovem 30. Name and address of person who completed cause of death (Item 23a) Type, Print) LOVEEN J. PUTHUMANA, 3110 GRACEFIELD ROAD, SILVER SPRING MD 20904 32. Registrar's Signaty 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

1 - For State Registrar		Cei	tificate of	Death	Mental Hyg	eg. No.	- 0	4/29
1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day	Yeer	3. Tîme of Death
		Carter			Decembe	r 4, 20	006	5:35 P. M
4a. Facility Name (If not institution, give s				r Location of Deat	h	4c. County		
Mandrin Hospice 5. Social Security Number 6. Sex		ge (In yrs. last birthday)	Harw	OOd If Under 24 Hrs	8. Date of Birth		2 Aru	
	M 2□F	76 Yrs.	Months Days	Hours Min.	(Month, Day,	Year JJU	Coun	lace (State or Foreign try) ington, D.C
Usual Residence of Decedent								
10a. State 10b. County	1	10c. City, Town or Lo					1	Od. Inside City Limits
Maryland Anne Ar	undel	Sever						1XXYes 2 No
10e. Street and Number 1813 Falcon Cour	· -		10f. Zip Code 211	<i>l. l.</i>	1	Og. Citizen of V		
	12. Was Decedent	Ever in U.S. 13 V		• •	Specify Yes or No-		e - Americ	
1 ☐ Never Married 2 Married	Amed Forces? 1 XYes 2 □	No UCL. I JAJ			Specify Yes or No- to Rican, etc.)	Blac	ck, White,	etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes Give	Aug. 1949	I∐Yes 2 X No	Specify:		Specify	.: B1a	ck
15. Decedent's Educ (Specify only highest grade	cation a completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	rking	16b. Kind of Bu	usiness/Inc	lustry
Elementary/Secondary (0-12)	College (1-4or	5+)	00 NOT use retired eral Pai:			C		
12th grade 17. Father's Name (First, Middle, Last)		Gen	erar rar		ne (First, Middle, M	Consti		011
Samuel Clevelan	d Carte	r		Lydia	Ashto		,	
19a. Informant's Name/Relationship (Type	pe, Print) (Wit	Fe) 19b. Mailin	g Address (Street	and Number or Ri	ıral Route Number,	City or Town,	State, Zip	Code)
Shirley Lucille Go			1813 Fal	con Cour	t; Severn	, Mary	land	21144
20a. Method of Disposition		20b. Place of Dispo-	sition (Name of natory or other place	ce)	Date 2	20c. Location -	City or To	wn, State
1 XBurial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1		· 1	.11,2006	Washir	igton	, D.C.
21. Signature of Funeral Service License	e 1	22 R	Name and Addre	ss of Facility	ny Morti	cians	Inc	
+ Comman	MAM	6	00 Kenned	ly Street	N.W.;Wa	shingto	n,D.	C. 20011
23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused to cause on each li	d the death. Do not ente	er the mode of dyin	g, such as cardia	or respiratory arre	est,		Approximate Interval Between
Immediate Cause (Final disease or condition	Meta	static '	Fauam	ious Ce	ell Ca	scino	Ma	Onset and Death
resulting in death)	Due to (or as	a consequence of):	1					11
Sequentially list conditions, b	. Gal	a consequence of):	C C	chace	6			ic would
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence or):						
that initiated events cresulting in death) Last	Due to (or as	a consequence of):						
	,						1	
0								
IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome		T			23d. Dat	e of delive	ry
in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		Ectopic pregnancy Other <i>(specify)</i>			Moi	nth	Day Year
9 Unknown	9□ Unknown							
Part II. Other significant conditions con	tributing to death b	out not regulting in the ur			23e. Did tob	acco use conti	ribute to th	e cause of death?
		at not resulting in the gr	iderlying cause giv	en in Part I.	1			
		at not resulting in the gr	nderlying cause giv	en in Part I.	1 □ Ye	s 2 ANO	3 🗌 Proba	ably 4 DUnknown
		at the resulting in the un	nderlying cause giv	en in Part I.	1 □ Ye 24a. Was ar	n 24b. V	Vere autop	psy findings available
		action resulting in the dr	iderlying cause giv	en in Part I.	1 ☐ Ye 24a. Was ar autopsy perform	24b. V	Were autoporior to condeath?	, –
25. Was case referred to medical examiner?		or not resulting in the dr		26. Place of Dea	1 ☐ Ye 24a. Was ar autops	24b. V	Were autoporior to condeath?	osy findings available poletion of cause of 2 No
examiner? 1 ☐ Yes 2 XNo	lospital: 1 ☐ Inpatie	ent 2□ER/Outpatien	t 3 DOA	26. Place of Dea	1 Yes 24a. Was are autopsy perform 1 Yes 2 ath (Check only one 5 Reside	24b. V y ned? XNo 1	Were autoporior to condeath?	osy findings available opletion of cause of 2 No
examiner? 1 Yes 2 XNo 27. Manner of Death 1 Natural 5 Pending	lospital: 1 ∐ Inpatie 28a. Date of Inju (Month, Da	ent 2□ER/Outpatien	3 □ DOA Oth 28c. Injur Wor	26. Place of Dea er: 4 □ Nursing F ⁄ at ⟨?	1 Ye 24a. Was ar autops; perform 1 Yes 2	24b. V y ned? XNo 1	Were autoporior to condeath?	psy findings available poletion of cause of 2 No
examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da	ent 2 □ ER/Outpatieni iry y Year) 28b. Time of Injury	t 3 DOA Oth 28c. Injur Wor M 1	26. Place of Dea	24a. Was ar autops; perform 1 Yes 2 ath (Check only one 5 Reside 28d. Describe ho	24b. Vined? 24b. Vined? 27 No 1 20 1	Were autoprior to confeath? Yes ar (Specify)	esy findings available abletion of cause of 2 No Rospice House
examiner? 1	28a. Date of Inju (Month, Da	ent 2□ER/Outpatien	t 3 DOA Oth 28c. Injur Wor M 1	26. Place of Dea er: 4 □ Nursing F ⁄ at ⟨?	1 Yes 24a. Was are autopsy perform 1 Yes 2 ath (Check only one 5 Reside	yed? XNo 1 No No	Were autoprior to confeath? Yes ar (Specify)	esy findings available abletion of cause of 2 No Rospice House
examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide	28a. Date of Inju (Month, Da	ent 2 ER/Outpatieni ury 28b. Time of Injury ury - At home, farm, stre	28c. Injur Wor M 1 eet, factory, office	26. Place of Dea er: 4 □ Nursing F ⁄ at ⟨ Yes 2 □ No	24a. Was ar autops; perform 1 Yes 2 ath (Check only one 5 Reside 28d. Describe ho	n 24b. V 5 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Were autoprior to confeath? Yes or (Specify) ed	osy findings available abletion of cause of 2 No Hospice House Route Number,
examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Inju (Month, Da) 28e. Place of Inju building, et	ant 2 □ ER/Outpatieni Iry y Year) 28b. Time of Injury ury - At home, farm, stre c. (Specify) of my knowledge, death f examination and/or inv	28c. Injur Wor M 1 set, factory, office	26. Place of Dea er: 4 □ Nursing F y at x? Yes 2 □ No	24a. Was ar autops; perform 1 Yes 2 ath (Check only one 5 Reside 28d. Describe how 28f. Location (Str. City or Town, and due to the care.	y yed? X No 1 nce 6 COthow injury occurr reet and Numbi	Were autoprior to confide the death? Yes ar (Specify ed	esy findings available abletion of cause of 2 No Rospice House Route Number,
examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 1 Yes 2 No H 6 Could not be determined	28a. Date of Inju (Month, Da. 28e. Place of Inju building, et	ant 2 □ ER/Outpatieni Iry y Year) 28b. Time of Injury ury - At home, farm, stre c. (Specify) of my knowledge, death f examination and/or inv	28c. Injur Wor M 1 set, factory, office	26. Place of Dea er: 4 ☐ Nursing F y at x? Yes 2 ☐ No ne, date and place pinion, death occu	24a. Was ar autops; perform 1 Yes 2 ath (Check only one 5 Reside 28d. Describe ho 28f. Location (Str. City or Town, and due to the carried at the time, da	y yed? X No 1 nce 6 COthow injury occurr reet and Numbi	Were autoprine to complete to complete to complete the co	esy findings available abletion of cause of 2 No Rospice House Route Number, ated. the cause(s)

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or othar traumatic event, the Medical Examinating Intelligible 1 at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

31. Date filed (Month, Day, Year)
DEC 0 8 2006 State Registrar

Edward J. Lee, M.D. 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D2360

Columbia, Maryland

11065 Little Patuxent Parkway

State of Maryland / Department of Health and Mental Hygiene 2 0 6 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Dec 5, 2006 Year **Physician** Elam I. Campbell 7:30 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Port Republic Calvert 1726 Grays Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct 23, 1933 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🔀 F 219-28-5740 73 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County worle. permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Importent; if item 27 is marked other then "naturel", or itema 23a or 28a-f ehoventy injury or other treumatic event, the Modical Examinal must be notified at 1 Yes 2 No Port Republic MD Calvert **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20676 1726 Grays Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Tes 2 No Baltimore, Maryland 21215-0036 Specify: Black à 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Inez Goff Daniel Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1726 Grays Road Port Republic, MD 20676 George M. Campbell, Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12/11/06 Prince Frederick, MD 4 □ Donation 5 □ Other (Specify) Carroll Western Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Sewell Funeral Home Glady a. 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intro cronial Meurita, **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of). Examine physicien and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as (IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown of Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ disorde 1 Yes 2 No 3 Probably 4 Nunknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 25 No certificete has 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home . Hesidence 6 Other (Specify) 2000 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🔲 Homicide Within 24 hours are To the Funerel Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1216/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mukesh Mathur, M.D. Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) DEC 6 2006 32. Registrar's Signeture State Registrar

19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Jean Pennock/ Personal Rep.

10450 Lottsford Rd., #4-46, Mitchellville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State

20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensile

2-11-2006 Fort Lincoln Crematory 22. Name and Address of Facility Simple Tribute, 1040 Rockville

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respurator Due to (or a a consequence of): Spirati

Approximate Interval Between Onset and Death Day

Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Sell Sis

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

Brentwood, Maryland

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 Pending investigation

6 ☐ Could not be

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

24a. Was an autopsy perform

24b. Were autopsy findings available prior to completion of cause of death? 2 **X**Vo

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manger of Death

1 Natural 2 Accident

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my online, death accurred at the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

DRIVE

29c. License number

2006

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 60001085 700

2006

VIMA AF Year) 31. Date filed (Month, Day, 1

32. Registrar's Signature

State

Physician

/Medical

Examiner

attending physician and for use as the burial-tran

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

ģ

Completed

Be

2

Certification:

Medical

DHMH 17 Rev 1/2001

Registra

			1- For State of Maryland / Depart State Registrar Certif	tment of Health and M ficate of Death		ene g. No.2 0 0 6	41298
I	Physici	an	Decedent's Name (First, Middle, Last) MARTIE LYONG CANCER	77.7	2. Date of Death Month	^{Day} , 2006	3. Time of Death
	/Media	al	MARIE LYONS CAMPBE 4a. Facility Name (If not institution, give street and number) 4	LLL b. City, Town, or Location of Death	December	4c. County of Death	9:05 P M
	Examir	ier	Homewood at Crumland Farms	Frederick		Frederic	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
н	Director		504-18-1706 X 88 Yrs.	vioritis days Hours Will.	Dec. 18,	1917 West	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	tion			10d. Inside City Limits
	Maryl f sho	ğ	Maryland Frederick Frederick				1 ☐ Yes 2 ☐ No
	h the	rec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	intry?
	23a c	ai	7401 Willow Road	21702		U.S.A.	
	within 72 hours after death with the Maryland one. than "natural", or Items 23a or 28a-f show the McClest Examiner must be notified.	Funeral Director	Armed Forçes?	is Decedent of Hispanic Origin? (Sp es, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
936	urs aft	5	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 3 X Widowed 4 Divorced Year or Dates:	Yes 2 No Specify:		Specify: Wh	ite
2-0	72 hours natural',	Completed	15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kir	nt's Usual Occupation	ing 1	6b. Kind of Business/li	
21	be filed within 72 ho tal Hygiene. id other than *natu event, the Micurol	nple	Elementary/Secondary (0-12) College (1-4or 5+)	nd of work done during most of work NOT use retired)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
12	filed w Hygier other ti	ပိ	17. Father's Name (First, Middle, Last)	emaker	e (First, Middle, M	Own Home	
land	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the M.	To Be	Logan L. Lyons	Arta S.		alderi Surname)	
Baltimore, Maryland 21215-0036	s 1 and 2 should I Health and Men Itsm 27 Is marks other traumatic			Address (Street and Number or Run 5. St. NW, Washin			p Code)
Je,	es 1 and 2 of Health f Itsm 27 r other tra	Î	20a. Method of Disposition 20b. Place of Disposition comptent, cremat	ion (Name of tory or other place)	Date 20	0c. Location - City or T	own, State
Ë	nit. Page artment o ortant: if Injury or			Cemetery 12/12	/06 U1	nion, West	Virginia
■ Balt	permit. Pages 1 a Department of Hee Important: If Itsm eny Injury or othe		120 Port States the disease of complication that any other death. Do not extend	lame and Address of Facility. ERT E. DAILEY & 1 NORTH MARKET S	T FRED	ERICK, MD	
	Physician /Medical	Si i	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	la accide	at		Interval Between Onset and Death
,8760,	iate be executed with the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of):				
P.O. Box 68	ne deeth certific the attending p thed for use as	Physician/Med		ctopic pregnancy other (specify)		23d. Date of deliv	ery Day Year
ds, P.	ires that tt signed by d be detac	þ	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did toba	acco use contribute to	
ecor	law requir es been si 2 should I	Completed	Alzleimers Osteonor	207:1	24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>		Con	V		performe	ed? death? No 1 ☐ Yes	
Vita	iclan: Th certificete ector, peg	Be	25. Was case referred to medical examiner? Hospital:	la.	h Check only one		
ō	Attending Physician: r death. sctor: After this certific by the funeral director.	. To	27. Manner of Death 28a. Date of Injury 28b. Time of	3LI DOA 3LI Nursing Ho	me 5 Residen 28d. Describe how	ce 6 Other (Speci	fy)
ion	nding F nth. r: After e funer	attor	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	28c. Injury at Work? M 1 Yes 2 No		,,	
Division of Vital Records,	al or Attendi after death. I Director: A d in by the fu	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Centifier (Check only one) Certifying Physician: To the best of my knowledge, death or control one) Certifying Physician: To the best of my knowledge, death or control one of the basis of examination and/or invessional manner stated.	ccurred at the time, date and place, stigation, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as e and place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)
			· Custin Darre	D0968	9	12/8/	20
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	•			
	1'		Austin Pearre, MD 300 West 9th Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature	, Frederick, MD	21/01		
	Sta Registr		DEC 1 2 2006	aste)			

Campbell, marie

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/laco A. Cornejo			or Print in Blad of Maryland / [Depart		Health and		l Hygiene	200	C 1100
Physicia		Registrar 1. Decedent's Name (First, Middle,La	st) Mayco Albert					2. Date of Death		3. Time of Death
Medical Examir			CORNEJO-VAI					Month December	Day Year 18, 2006	1723 hrs
		4a. Facility Name (if not institution, gi	ve street and number)		4	b. City, Town, or	Location of I	Death	4c. County of Dea	
-		4000 38th Street 1A				Brentwood	r If Under 2	Alles To Date of Dist	Prince Georg	
Funeral Director		5. Social Security Number None 6. S			birthday)	If Under 1 Yea Months Days		Min	n(MM/DD/YYYY) 9. B	ign
Director	ļ		X M 2 F	24	Yrs.			April	20, 1982	ountry) El Salvado
any	_ L	Usual Residence of Decedent 10a State 10b. County	10	c. City, To	own or Location	on				10d. Inside City Limits
ž		Maryland Prince	e George's	Вт	entwoo	nd				1 X Yes 2 No
daryland 28a-f show 1 at once.	Director	10e. Street and Number	e deorge s		CHEWOC	10f. Zip Code		10	g. Citizen of What Co	untry?
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136 hin 72 e than sdical		4	ounego (, , o, o, ,			Unavai	lable		Unava	ilable
21215-0036 Juld be filed within 72 hours after Mental Hygiene. marked other than "natural".	Completed	17. Father's Name (First, Middle, Las	et)					Name (First, Middle, M	laiden Surname)	
215 be fill ntal H rked	Be		rto Cornejo					Delia Vall		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	리	19a. Informant's Name/Relationship (,		er or Rural Route Num		
imore, MD 2 Pages I and 2 shou ment of Health and N ant: If item 27 is n or other traumatic	-	Julio Alberto C	ornejo - Fai			34th St tion (Name of ce		Brentwood,	20c. Location - City	
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 X Burial 2 Cremation 3	Removal from State	cre	ematory or oth	er place)				
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Baltimo permit. Page Department c Important: injury or ott	1	21. Signature of Funeral Service Lice	ensee					Home P A		timore Ave. 11e, MD 20781
Physician	\dashv	23a. Part I. Enter the disease, or con	pplications that caused the	e death. D						Approximate Interval
/Medical		failure. List only one cause on	each line. a. Seizure dis or	rdor						Between Onset and Death
xaminer		Immediate Cause (Final dis. *** or condition resulting in de to	Due to (or as a consequ							
The same of the sa		Sequentially list conditions,	0							
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ox 68760, eath certificate be executed eath certificate be united to the set the burial - transit	a		d. v							
0, be ex sician	edical	X UNPENDED	X AMENDED #1,2	3a,27	perME,	g863, 1/24	∙/07 TT		Lasia	1
68760, certificate be ending physici	sician/Me	IF FEMALE 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregna		tal death 3	Ectopic p	pregnancy	23d. Date of deliver	ery Day Year
x 61 th cert tendir	Sign	past 12 months?	4 Pregnant at tim	ne of deat	<u> </u>	ner (Specify)			A.	
Bo le deat the at	Phys	1 Yes 2 No 9 Unknow	9 OHKHOWH		***			1 220 Did to	hanna waa aantiib da	e the eques of death?
Division of Vital Records, P.O. Box 68760 rat or Attenting Physician: The law requires that the death certificate b its after death. al Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the bu	by P	Part II. Other significant conditions	s contributing to death b	ut not res	ulting in the u	nderlying cause	given in Part		bacco use contribute 2 No 3 Pr	
lS, F										autopsy findings available
tal Records, cian: The law requir certificate has been sector, page 2 should l	Completed							autop		completion of cause of
Vital Reco ysician: The lav his certificate ha director, page 2	Con						(5	1 ✓ Yes	2 No 1 🗸	Yes 2 No
ician:	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 7	R/Outpatient		Other	Nursing Home 5	Residence 6 🗸 Ott	er Scene
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ivision I or Attent after death Director:	ficat	2 Accident Investiga 3 Suicide 6 Could no	28e Place of Injur	y - At hon	ne, farm, stree	et, factory, office	building, etc.			Rural Route Number, City
Divisior pital or Attencours after death eral Director: filled in by the	Certification:	Suicide 6 Could no determine						or Town, S	tate)	
Hos 24 h Fur		29a. Certifier 1 Certifying Phys	ician: To the best of my k							
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examin	er: On the basis of examinand manner stated	nation and	d/or investigat			urred at the time, date		
	ž	29b. Signature and title of certifier	/			29c. Licen:			29d Date signed (A	
		//_/	1			O.C.	IVI.E.		December 19,	
CR(4)		30. Name and add, ss of wrs in wh Mary G. Ripple MD. D	complete Lause of dealer			Penn Stree	t. Baltimo	re, MD 21201		
6100	ate	31. Date filed (Month, Day Year)	32. Registrar's				-,			
Regist		31. Date filed (Month, Day, Year) OFC 2 1 2006	parem &	7. 1	Jours!					

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2	Physic /Medi		Decedent's Name (First, Middle, Last) CATHERINE		DAVIS				2. Date of Dea Month DECEMBI	Dav	3 2006	3. Time of Death 10:20 P M
-	Exami	ner	4a. Facility Name (If not institution, give s PRINCE GEORGE S H 5. Social Security Number 6. Sex	OSPITAL	a la at histhela 1	4b. City, T	СН	Location of D EVERLY If Under 24 I		PR	County of Deat	ORGE'S
, 92	Funeral Director			^{1M 2} ₹ 58	yrs.	Months	Days		Hrs. 8. Date of Birth (Month, Day DECEMBI	h 1947 K Year) ER 4	9. Birt Co SOU	hplace (State or Foreign ountry) TH CAROLINA
	atter death with the Marylan or Items 23s or 28s-f ehow	Funeral Director	MD PRINCE G		TEMPLE	HILL:	Code			•	en of What Co	10d. Inside City Limits 1. Yes 2 □ No untry?
980	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-1 show ha Mudical Experiment with be notified at	b	4216 LYONS STREET 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1			spanic Origin? i, Mexican, Pu Specify:	? (Specify Yes or No- uerto Rican, etc.)	1	J.S.A. 4. Race - Ame Black, White Specify: B	
Maryland 21215-0036	be filed within 72 hours after de ital Hygiene. Id other than "natural", or Item event, the McCoal Examiliar.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) 5+	(Give	tent's Usual kind of work OO NOT use TEACI	done du retired)	tion uring most of	working		od of Business/	
yland	should be filed ind Mental Hygi marked other umatic event, II	To Be (17. Father's Name (First, Middle, Last) UNKNOWN					AMAND.	Name (First, Middle, A MOORE			
	d2: thar thar trau		19a. Informant's Name/Relationship (Typ. JAMAL DAVIS/SO 20a. Method of Disposition	N	19b. Mailin 1042 Place of Dispos	SAINT	MIC	HAELS	Rural Route Number DRIVE MITO	CHELI	LVILLE,	MARYLAND
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 eny injury or other once.		N Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State	Cemetery, Cren HURCH C 22	EMETEI Name and	RY Address	12 of Facility		COLU	TUNERAL	OUTH CAROLIN
7	Cate be executed hysician end physician end physician end street the burial-transit	Examiner	23a. Part1. Enter the disease or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flasty, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse SEPS IS Due to (or as a conse LEUKEM I Due to (or as a conse	ath. Do not enter quence of):	er the mode	of dying,	such as card				Approximate Interval Between Onset and Death
.O. Box 68760,	ath certifi ttending or use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \) Unknown	NON - HODGN Ic. If yes, outcome of pregrature time of 90 Unknown	nancy al death 3	Ectopic prec	gnancy			23	3d. Date of delive Month	very Day Year
0	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions cont	ributing to death but not re	sulting in the un	derlying cau	ise given	in Part I.				the cause of death?
al Records,	The ate h page	Completed							24a. Was a autops perform 1 \(\text{Yes} \) 2	у	24b. Were aut prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of 2젒 No
Division of Vital	Hospital or Attending Physician: 44 hours alter death Funeral Director: Aller this certific tely filled in by the funeral director,	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be delemined	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28d	Other c. Injury a Work? 1 \(\triangle Ye	4 Nursing	Death Check only one Home 5 Reside 28d. Describe ho 28f. Location (Sti	ow injury	occurred	al Route Number.
วิ	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edicai Cert	29a. Certifier 1X Certifying Physi	building, etc. (Special Country of the basis of examinant manner stated.	owledge faith	occurred at	the time	date and pra	City or Town		nd marmer as : lace, and due!	stated. to the cause(s)
)		Mec	29b. Signature and title of certifier ### ### ############################	end mainer states.		29c. L	_icense r	number	25	9d. Date :	signed (Month	Day Year)
3	Sta	te	31 Date filed (Month Day Year)		661 400	SPITAL	- 1	×	CHEVERLY	, M	7 20%	185
*	Registr	ar	DEC 1 2 2006	Decen D.	upera							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 6 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2006 7:024 M James Dillon recember 9. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctor's Community Hospital Lanham 8. Date of Birth (Month, Day, Year) April 16, 1936 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1**X** M 2 □ F Yrs. Washington DC 70 577-50-0528 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1√2Yes 2 No Director Lanham Maryland Prince George's 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 20706 8409 Red Wing Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Builder Private and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Lewis James R. Dillon 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is rany injury or 8409 Red Wing Lane, Lanham MD 20706 Janice Dillon 20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory 12/12/2006 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 P rt1. Enter the disease, shock, or heart fulure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in hy one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2001001h /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-trar Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown cate has been signated bage 2 should b axlery chosens Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed? Yes 2 Hyperlension funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No J Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 hame and address of person who completed cause of death (Item 23a) (Type, Print) Handrer forkway, Greenbelt, MD 20770 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DEC 1 2 2006

The law requires that the death certificate be executed physician and s the burial-transit Division of Vital Records, P.O. Box 68760, the attending jo signed by page 2 should be been certificate has Hospital or Attending Physicien: funeral director. this After filled in by the within 24 hours after deat To the Funeral Director:

Physician

/Medical

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1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

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permit. Pages 1 and 2 shoul Department of Health and Mc Important: If Item 27 is mark any njury or other traumations.

Physician /Medical

Examiner

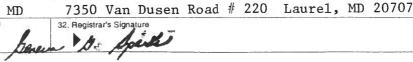
Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2006

Crita K. Shah,



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 20251

12/8/2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician GEORGE** DAVIS 2006 12 05 1935 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/10/1918 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F 88 Director Mississippi 436-26-5154 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at ₩ Yes 2 No MD PG Bowie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12803 Pittmans Promise Court 20720 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 42-46 1 ☐Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/2 No <u>م</u> Specify:Black 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DDS/ 8 years Dentist Self/Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty McMillian Sam Davis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Davis - Daughter 8009 Greenbury Drive; Greenbelt, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 12/13/2006 Suitland, Maryland Lincoln Mem. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Freeman Funeral Services 5801 Cleveland Avenue
Riverdale, MD 20737 21. Signature of Juneral Service Licenses 23a. Part1. Enter the disease, or do notications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocard **Physician** immediate disease or condition resulting in death) /Medical Due to (or as a conseque ce of) Examiner Sequentially list conditions, if any, leading to in reduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending properties for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2**√**2No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 KER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Atte.. اه 24 hours after death. معا Director: Afte After Certification: 5 ☐ Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0051791 December 5,2006

State Registrar

31. Date filed (Month, Day, Year)

lamara

amara K.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O

9901 Medical Center Drive, Puckville, MD 20850 32. Registrar's Signature

			1 - For Registrar	• •		d / Depa	artment of	f Health a		ntal Hygi	9	06	41305
25.	A. 91	8	Decedent's Name (First, Middle	Last)					2	Date of Death	1		3. Time of Death
-	Physici		Felton Day	71c					D	Month ecember	Day - 4 2	Year 2006	9:53 P M
	/Medic Examir		4a. Facility Name (If not institution,		oer)		4b. Cily, Town	n, or Location of		ecember	4c. County		1 7 J J F
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0.	Funeral			6. Sex 7		last birthday)		ar If Under 2		Date of Birth (Month, Day,			olace (State or Foreign
	Director		260-30-0358	1 XM 2 F	8	6 Yrs.	WOTHERS	y3 110013		ec. 25,		_	eorgia
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	ocation						10d. Inside City Limits
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	ns 2:	era	11. Marital Status	12. Was Deced	ent Ever in U	.S. 13.	Was Decedent of If Yes, specify C		744 jin? (Specif	fy Yes or No-			States can Indian,
ထ	or ite	Ē	1 ☐ Never Married 2 📉 Marn	Armed Force ad 1 Tyes 2 If Yes, Give		1			Puerto Rio	can, etc.)	Blac	ck, White,	etc.
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21215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28e-f ahow digal Ezanalinar musi be notified at	Completed by Funeral Director	15. Decedent' (Specify only highes	s Education grade completed)		(Give	dent's Usual Oc kind of work do	ne durina most	of working	1	6b. Kind of B	usiness/In	dustry
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	iled v dygie ther t	ပိ	6th 17. Father's Name (First, Middle, L	acti		<u> </u>	Contru	ction Wo		First, Middle, M		Priv	ate
anc	t be f	Be						10. MOLINI	S Name (F				
2	d Me d Me mark matic	은	19a. Informant's Name/Relationsh	Davis		19h Maili	ng Address (Stre	and Alumbar	r or Qural C		cca Wh		
Maryland	d2s th an trau		98 1993	W26 81		1							7 C009)
	Heal Heal tem 2	- 12	Rosenna Barne 20a. Method of Disposition	s/Daughter	20b. F	Place of Dispo	3 Steubs		Date		Oc. Location -		own, State
01	ages ant of it: If i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		are		natory or other p		12/11	/2006	D		dM. I
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at ances.	1	21. Signature of Funeral Service L		1		2. Name and Ad						d, MD
ä	Department Department		1 John T	Stana	VIII			Benning					0019
, i	Na Na		23a. Part1. Efter the disease, or shock, or heart failure. List of	complications that cau	sed the deat	h. Do not ent							Approximate Interval Between
	Physician	3	Immediate Cause (Final disease or condition			1.	-1 T.C.						Onset and Death
	/Medical		resulting in death)	Due to (or	as a conseq	uence of):	al Infa	rction					1 Hour
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	and -trans	каш	that initiated events resulting in death) Last	c. Due to /or	as a conseq	uanaa af):							
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687			17.	d									
×	death certifica e attending ph id for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco							23d Dai	te of delive	any
Вох	d for	clai	in the past 12 months?	4□Pregnar	h 2 ∐ Feta nt at time of d		Ectopic pregna Other (specify)				Mo		Day Year
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s, P	The law requires that the death certific Ite has been signed by the atlending p age 2 should be detached for use as	by P	Part II. Other significant condition	s contributing to dea	th but not res	ulting in the u	nderlying cause	given in Part I.		23e. Did toba	icco use cont	ribute to ti	he cause of death?
ğ	w require been sign should t									1 🗌 Yes	2 XNo	3 Prot	ably 4 Unknown
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<u> </u>		Ю								perform 1 Yes 2	apd? (death?	
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n C	ding Phy h. After thi funeral c	e e	27. Manner of Death 1		Day Year)	28b. Time of Injury	V	Vork?		d. Describe how	v injury occurr	ed	
Sic	ten feat for:	cat	2 Accident investig	ot be	Claricana At la			Yes 2 N		1			
Division	or A after Direction by	Certification:	4 Homicide determine	ned 286. Place of building	, etc. (Specif	y)	eet, factory, office	ce	281	City or Town,		er or Hura	al Route Number,
_	o Hospital or Attano 24 hours after death Funeral Director: etely filled in by the		29a. Certifier 1 Certifying	Physician: To the b	est of my kno	wledge, deat	n occurred at the	time date and	Inlace and	d due to the cau	iso(s) and ma	anor as s	tatod
	To the Hospital or At within 24 hours after of 10 the Funeral Directumbletely filled in by	Medical	(Check only 2 Medical E	xaminer: On the bas and manne	is of examina	tion and/or in	vestigation, in m	y opinion, death	occurred	at the time, dat	e and place,	and due to	the cause(s)
	To the I within 2 To the C mplet	Me	29b. Signature and title of certifier				29c. Lice	ense number		29	d. Date signed	d (Month,	Day, Year)
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			Philip !	Wisotsky,	M.D.	12070	Old Lin	e Centr	o, #2	C7 Weld	biff, N	D Z	0607
	Sta		31. Date filed (Month, Day, Year)	See 32. Reg	gistrar's Signa 📤	ture	j						
1	Registr	aı	DEC 0 8 2006	Dereva	10.	Marie							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Alice Elizabeth Davis 12 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7843 Pheasant Lane Salisbury Wicomico If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1 10 Birthplace (State or Foreign Country) Months 1 □ M 2 □ F 159-40-3501 Director 58 Yrs PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location rthan "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at 10d. Inside City Limits Directo MD Wicomico 1K Yes 2 No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 7843 Pheasant Lane Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 end 2 should be filed within 72 hours after Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 28 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 K&L Microwave Micro-Chip Assembler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Thomas McNutt Mary Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itam 27 James Davis (husband) 7843 Phesant Lane, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of h Important: if Ita any Injury or of once. 20c. Location - City or Town, State 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 4 Donation 5 Other (Specify) 12/11/2006 Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signator of Funeral Service Licenses 108 William St., Berlin, MD 21811 23a. Part1. Enter me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Myound /Medical Due to (or as a consequence of). Examiner S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last woman Due to (or as a conseque ve physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. by Physician/Medical attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death Day ned by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s certificate has b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed of Vital 212No 1 Yes To the Hospital or Attending Physician: : After this certific a funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ M6 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation s effer de... 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours efter To the Funeral Dire completely filled in b Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and little of pertifier 29c. License number DOUSU614 Ð 36. Name and address of perion who completed cause of death (Item 23a) (Type, Print) 1205 Pernberan Dr Sute 101, Solisbury m BAIR 31. Date filed (Month, Day, Year) 32. Re trar's Signature State DEC 13 2008 Registrar

Funeral

Director		035-34-9
ns 23a or 28a-f show must be notified at	uneral Director	Usual Residence 10a. State MD 10e. Street and N 8484 16t 11. Marital Status 1 X Never Ma
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Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, the Monee.		20a. Method of Di 1 ☐ Burial 2 4 ☐ Donation
Department Important: any injury once.		21. Signature of E
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		For State Registrar		Stat	e of Mar	yland /		rtment of tificate of			ntal Hy	giene Reg. No	20	06	413	07
Dhooisis		1. Decedent's Name	e (First, Middle	, Last)							2. Date of De	_	ıv	Year	3. Time of D	
Physicia /Medic	_	Paul La	urice	Desmar	ais					D	ecembe	er 7	, 20	0 ^Y 6 ^{ar}	7:15	Рм
Examin		4a. Facility Name (I		-	nd number)			4b. City, Town,						of Death	17	
		Holy Cro 5. Social Security N		6. Sex	7 0-0 /	'In yrs. last t	n i with all our ch	Silver	_		B. Date of Bi		oneg	omer		F
Funeral Director		035-34-9	784	1 X M 2		55	Yrs.	Months Day	s Hours	Min. J	an 31	19, Year	51	Rhode	place <i>(State</i> or i ntry) e Islan	d
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23a o Ist be	Funeral Director	8484 16th	Street	#613				20910				USA				
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or other		20a. Method of Disp 1 ☐ Burial 2	XCremation		from State	ceme	tery, cren	sition (Name of natory or other p		Date 12/11				City or To	·	
epartme nportant ny injury nce.		4 □ Donation 21. Signature of Fu			4		GC	Name and Add	ress of Fac	mation	Serv	ice	P.0) . Bo:	x 784	
	_	Gleve	Jy F. 1	balan	10			everly I					arks	ville		1029
5			irt failure. List	complications only one cause	e on each line.	ie death. De	o not ente	er the mode of a	ying, such a	as cardiac or	respiratory a	ırrest,			Approximate Interval Betwee Onset and De	een eath
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Ifter deat	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determ	ot be	Place of injury building, etc.	/ - At home, (Specify)	farm, stre	eet, factory, offic	e	28	f. Location (City or To			ber or Rura	al Route Numbe	er,
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ledical Ce	29a. Certifier (Check only	1 Certifyin	Examiner: On	the basis of e	xamination	ge, death and/or inv	occurred at the	time, date	and place, an	nd due to the	cause(s	s) and mand place,	anner as s and due t	stated. to the cause(s)	
thin 2 the mplet	Med	one) 29b. Signature and	title of certifier		d manner state	ed.		29c. Lice	nse numbe	r		29d. Da	ate signo	d (Month	Day, Year)	
¥ 6		255. Signature and	has N	10				D641		·				2 8 ,		
7		30. Name and add	ress of person	who completed 1500	cause of dea Forest	th (Item 23a Glen	Rd.	Silver	Sprin	ng, MD	20910					
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17 Rev 1/20	001						7					-				

			State of Maryland / Dep	partment of Health and Me ertificate of Death		41308
	Physici	an	Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day Year	3. Time of Death
	/Medic Examin	Sear I	Maryanne Christina Dublin 4a. Facility Name (#f not institution, give street and number)	4b. City, Town, or Location of Death	12-11-06 4c. County of Deat	th
		3	Carroll Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda.	Westminster // If Under 1 Year If Under 24 Hrs. 8.	Carroll	hplace (State or Foreign
ľ	Funeral Director		219–50–6045 1 M 2 XF 57 Yrs.	Months Days Hours Min.	(Month Day Year) Co	Ltimore, MD
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits
	e Many 3a-f sh	Director	MD Carroll Westmins	ter 		1 ☐ Yes 2X No
	with the se or 21	i Dire	1508 Bachmans Valley Road	10f. Zip Code 21158	10g. Citizen of What Co	ountry?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show say injury or other traumatic event, the Medical Extinductional be notified at once.	by Funerai		Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- lan, etc.) 14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	natur	Completed	(Specify only highest grade completed) (Given	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business,	Industry
2121	d within piene. r then	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	ling Clerk	Carroll Ho	spital Center
	be filed ital Hyg id othe event,	Be	17. Father's Name (First, Middle, Last) Albert Darago, Sr.	18. Mother's Name (F	First, Middle, Maiden Sumame)	
Maryland	should nd Mer marke imatic	ဥ		ling Address (Street and Number or Rural R		Zip Code)
	and 2 Balth at n 27 Is			Bachmans Valley Roa		
Baltimore,	Pages 1 Iment of Hi Iant: If iter jury or oth		4 Donation 5 Other (Specify)	ematory or other place) Cremations, Inc.	_	
Bal	permit Depar Impor eny in		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Pritts	Funeraol Home &	Chapel, P.A.
			23a. Page 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	MYOCARPIAL IN	FARCTION	Oliset and Death
· · · · ·	Examiner					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
o,	te be executed ysician and ie burial-transit	Exar	that initiated events resulting in death) Last			
68760,	* × •	dical	d			
.O. Box	Physician: The law requires that the death certificate be exthis certificate has been signed by the attending physician ratidirector, page 2 should be detached for use as the buriar	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date ol del Month	ivery Day Year
Δ.	quires that n signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco use contribute to	the cause of death?
Records,	sician: The law requir certificate has been si irector, page 2 should I	Completed			autopsy prior to performed? death?	itopsy findings available completion of cause of
Vital	cian: 7 ertifical	BeC	25. Was case referred to medical examiner?	26. Place of Death (C	1 ☐ Yes 2 No 1 ☐ Yes Check only one)	2 No
of	ding Physi After this of funeral dire	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time		5 Residence 6 Other (Spe 1. Describe how injury occurred	city)
ion	ath. r: Afte	ation	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation			
Division	or Attender de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	treet, lactory, office 281	. Location (Street and Number or Ru City or Town, State)	ural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and investigation, in my opinion, death occurred	due to the cause(s) and manner as at the time, date and place, and due	stated. to the cause(s)
		Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont	
	MJZ		30, Name and address of person who completed cause of death (Item 23a) (Typ	D003026	3 12-11-	الم الم
1000	6		Francis Khoo, M.D. 200 Memorial	Ave., Westminster, M	D 21157	
	Sta Registi		31. Date liled (Month, Day, Year) 32. Registrar's Signature	South &		
	ar Albert	- Au	DEC TO TOO DOUGHES YE	AND THE PROPERTY OF THE PARTY O		

DHMH 17 Rev 1/2001

Registrar

DEC 1 1 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Helen Brown Eisenhart 2006 December /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctors Community Hospital Lanham 8. Date of Birth (Month, Day, Year)

Mar. 12, 1915

9. Birthplace (State or rown Country)

North Dakota If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days 1 ☐ M 2 🔀 F Yrs 91 113-10-4718 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes X☐ No Directo Maryland Prince George's Mitchellville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20721 10450 Lottsford Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No White Specify. Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) The Episcopal Church Church Service Volunteer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ina Etta Denning Henry Brown ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10450 Lottsford Rd., Mitchellville, MD Earl E. Eisenhart, Jr. - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory Dec. 7, 2006 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service License 20781 4739 Baltimore Ave., Hyattsville, MD 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can be on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): augirati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consecuence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform performed? 1☐ Yes 2☐ No 25. Was case referred to medical 26. Place of Death Check onl one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 21714 1 Thipatient ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident

Examiner death certificate be executed attending physician and for use as the burial-transi Box 68760. signed by the a P.O. Records, peen page 2 s certificate or Vital Physician: this

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

ith and Mental F

Health em 27 i

Department of the Important: If ite any injury or other

Physician /Medical

と/senhart Baltimore, Maryland

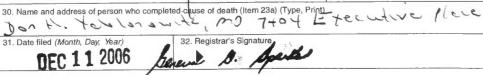
funeral After death. neral Director: A after To the Hospital within 24 hours a To the Funeral Completely filled Medical

Division

State Registrar

31. Date filed (Month, Day, Year) 11 2006

6 Could not be determined



and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 200

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Maryland		artment of H			giene	106	4.1	311
	3.	J	Decedent's Name (First, Middle, Last,	1				2. Date of Dea	th		3. Time	e of Death
	Physici /Medic		Marjorie Geitz Es	tilow				Decembe	r 10,	2006	9	00 P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		th		nty of Death		
ŧ.	*		Homewood Nursing		11:11 1	Frederi				ederi		
	Funeral Director		5. Social Security Number 6. Sec. 153-03-2597	38F -	5 Yrs.	Months Days	If Under 24 Hrs Hours Min		, Year)	Cour	itry)	te or Foreign
н.			Usual Residence of Decedent	0.				001. 25	, 1921	New	Jers	еу
	inylan ihow	_	10a. State 10b. County		Town or Lo					1		e City Limits
	8a-fs	Directo	Maryland Frede	rick	Fred	lerick						′es 2. № No
	death with the Maryland ims 23s or 28a-f show rnust be nulling at		10e. Street and Number 10185 Winston Dri	17.0		10f. Zip Code	1701		10g. Citizen o	ted Si	•	_
	ns 23	Funeral		12. Was Decedent Ever in U.S.	13. V	Vas Decedent of His		Specify Yes or No-		ace Amend		
٥	or Itar		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	l II	Yes, specify Cubar	n, Mexican, Pue	rto Rican, etc.)	В	lack, White,	etc.	
9500-CI	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "naturat", or Itams 23c or 28a-f show aumatic avant. If e Maryles Ex., niter rust be nulliked at	d by	3₺ Widowed 4 Divorced	If Yes, Give Year or Dates:		Yes 2K No	Specify:		Spec	cify: Whi	Le	
ក	n 72 h "nati	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	lent's Usual Occupa kind of work done d DO NOT use retired,	uring most of wo	orking	16b. Kind of	Business/Ind	dustry	
7 7	l withi iene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		istrative		nt	Educ	ation		
	e filled Il Hyg other	a	17. Father's Name (First, Middle, Last)		7(111111)	ISLIALIVE		me (First, Middle,		ation _{ame)}		
/land	uld be Vental Irked o	To B	William Daniel Ge	itz, Sr.			Margare	et Meyer				
Mar	2 sho and lama rauma	1	19a. Informant's Name/Relationship (Ty	•		-		ural Route Number			Code)	
ຂ ທົ	1 and 1ealth sm 27 ther t		Laura Elizabeth Est		-	5 Winston sition (Name of					Chata	
sammore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 Ia marked any injury or other traumatic and DES.		1 ☐ Burial 2 🛣 Cremation 3 🗆 F	lemoval from State cen	netery, crem	natory or other place		. 11,	20c. Location			
	artme ortani injury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens	A		Cremator	-		Frederi			
n	Deparent Important in Superior		1 111	7	Re	sthaven : 01 Catoci	Funeral	Services Hwy. Fr	, Skko	t Cody	7 P.A	\ . \ 1
ľ	'n		23a. Part1. Enter the disease, or complete shock, or heart failure. List only or	cations that caused the death.	Do not ente	er the mode of dying	, such as cardia	c or respiratory arr	est,	N , 1111	Approxim Interval i	nate
0	Pnysician		Immediate Cause (Final disease or condition	/	tr	1Ke					Onset an	
	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):						/ 00	00/(
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	nce of):	100000000000000000000000000000000000000						
	uted d ansit	Examiner	cause. Enter Underlying	, , , , , , , , , , , , , , , , , , , ,								
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0		/Med	IF FEMALE:	3c. If yes, outcome of pregnance	14.7				1			
DOX	death of attended for us	Physician/Me	in the past 12 months?	1 Live birth 2 Fetal di 4 Pregnant at time of dea	eath 3	Ectopic pregnancy Other (specify)				ate of delive fonth	ny Day	Year
j.	the d	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
,	The law requires that the death certif tie has been signed by the attending page 2 should be detached for use a	by P	Part II. Other significant conditions con	tributing to death but not resulti	ing in the un	derlying cause give	n in Part I.	23e. Did to	bacco use co	ntribute to th	e cause o	of death?
necoras,	equire ien sig ould b		ATTIM,	+ Ball.	a 16 8			1 🗆 Yı	es 2□No	3 🗌 Prob	ably 🗡	aknown
Š	law r las be	Completed	Athel	050/4/0/16	- 17:	eact	Dijuaj	e 24a. Was a autops	SV .	. Were autor	osy findin	gs available of cause of
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ō	g Phy er this eral d	-	27. Maprier of Death	28a. Date of Injury 2	VOutpatient 8b. Time of	28c. Injury	at	Home 5 Reside			"	
SION	ath. ath. ir: Aft	atlo	Natural 5 Pending investigation	(Month, Day Year)	Injury	Work M 1 □ Y	f es 2□No					
<i>n</i> ≥	ter de irecto	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Num n, State)	nber or Rura	Route N	umber,
2	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director After this certificate has completely filted in by the funeral director, page 2.	0	200 Cortifier	Noise. To the best of a deal	adaa							
	a Hos 24 hc 3 Fund etely f	edical	29a. Certifier (Check only one) Certifying Physical Certifying P	sicien: To the best of my knowle ner: On the basis of examination and manner stated.	euge, death n and/or inv	estigation, in my op	e, date and placi inion, death occ	e, and due to the ca urred at the time, d	ause(s) and mate and place	nanner as sta e, and due to	ated. the caus	Θ(s)
	To the within To the comple	Me	29b. Signature and title of certified	1//		29c. License	number	2	9d. Date sign	ed (Month, L	Day, Year	')
			MA	ne IA	1	D 16	5428		12	1111	150	
	a		30. Name and address of person who co	mpleted cause of death (Item 2	3a) (Type, F	Print)	V. C.	701		/ / /	1-6	
	10		Casper Cline, M.D.			Frederick	c, MD 21	.701				
	Sta Registr		31. Date filed (MonDER Year) 2 20	32. Fegistrar's Signatur	* A	machine .						

0000 12/10/06

Known to physicianas mayone Entitous

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** DECEMBER 9 2006 ANNA ENION Ρ. 3:45 am /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Chestertown Nursing & Rehab Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Nov 20 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** 1916 Pennsylvania 1 □ M 2 🔀 F 169-40-9457 90 Director Usual Residence of Decedent filed within 72 hours after death with tha Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or itams 23a or 28e-f show the Medical Examiner rust be notified at MD Kent Galena 1 Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14090 South Mill Rd. 21635 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ XNo Specify: Specify: δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiena. Importent: If item 27 is marked other than "ne any injury or other traumatic event, IT a Meule once. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rachel Trosino Domenico Palombo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $14090\ South\ Mill\ Rd.\ Galena,\ MD.\ 21635$ 19a. Informant's Name/Relationship (Type, Print) (son) Samuel Enion 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chester Rural Cem 12/15/06 Chester, PA. ' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Galena Funeral Home of Stephen L. Sc 118 West Cross St. Galena, MD. 21635 Schaech M00510 23a Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, brick, or high relations. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Immediate Cau e (Final disease or condition resulting in death) **Physician** 5 days /Medical **Examiner** tovo Sclevotic Cardio Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate ba executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HTW; Hypothywoid; GERD; HM; CKD; 1 X Yes 2 No 3 Probably 4 Unknown Completed Docourative Toint Disane Mid!; OStoopeross 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Tyes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1. Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50996 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil Stoddard, M.D. 100 Brown St. Chestertown, MD. 21620 31. Date filed (Month, Day, Year) 32. Register's Signature State DEC 1 1 2006 >

DHMH 17 Rev 1/2001

Registrar

Replacement

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

,		1 - For State Registrer	State of Maryland	•	tificate of			Reg. No. 2	006	4131
Physic /Medi		1. Decedent's Name (First, Middle, Last James B.	Early				2. Date of Month	Day	Year 2006	3. Time of Death
Exami		4a. Facility Name (If not institution, give Laurel Regiona			4b. City, Town, o	r Location of Dea	uth		unty of Death ince	Georges
Funeral Director		237-40-0049	7. Age (In yrs. It	* .	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Birth Day, Year 0, 1932	9. Birthp Cour	place (State or Foreign ntry) N.C.
Aaryland	o	Usual Residence of Decedent 10a. State 10b. County D • C •		.Town or Lo Washi	ngton				1	0d. Inside City Limits
with the h	Il Director	10e. Street and Number 103 Missouri A	1		10f. Zip Code	0011		_	of What Cour	ntry?
within 72 hours after death with the Maryland iene. r then "natural", or items 23e or 28e-f ehow the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:		Vas Decedent of H i Yes, specify Cub	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or roto Rican, etc.)	1	Race - Americ Black, While, ecify: Bla	elc.
within 72 hou ene. then "natura he Madical E	Completed	15. Decedent's Edu (Specify only highest grad	cation	(Give life. I	lent's Usual Occup kind of work done DO NOT use retire	during most of w d)	orking	16b. Kind	of Business/Ind	
be filed Ital Hyg Id othe event,	Be	17. Father's Name (First, Middle, Last) Clifton	Edwards	secu	rity Gu		ame (First, Midd Essi	lle, Maiden Sur		
s 1 and 2 should f Health and Men Item 27 is marke other traumatic	To	19a. Informant's Name/Relationship (T) Monnie C. Gordor	rpe, Print)		g Address (Street		Rural Route Nun	nber, City or To	own, State, Zip	
m Q		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	20b. Pl	lace of Dispo emetery, cren	sition (Name of natory or other place od Cemet	сө)	Date	20c. Locati	ion - City or To	
permit. Page Department Important: fi any injury or		21. Signalure of Funeral Service Licens	unt	Hu	Name and Addre	ss of Facility Home 9	08 Ken	nedy S	st.NW.	Wash.DC
Physician /Medical	١.	23a. Part1. Enler the disease, or complete shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line. Sepsis Due to (or as a consequ		er the mode of dyir	ng, such as cardi	ac or respiratory	arrest.		Approximate Interval Between Onset and Death
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0 - 0	Completed	Renal Failure	e, Shock				24a. Wa au pe 1 Yes	topsy rformed?	4b. Were autoprior to condeath?	psy findings available npletion of cause of
sician: certific rector,	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No	Hospital: X Inpatient 2	ER/Outpaties	t 3□ DOA Oth	or.	eath (Check only	y one)	Other (Sees)	4
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Physician Medical Examiner Part Image I				23a. Part1. Enter the disease, o	r complications that caused only one cause on each lin	the death. Do not en	ter the mode of dyir	ng, such as ca	ardiac or respiratory a	rrest,			
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Total Continue Tota				resulting in death)	α.	a consequence of):							
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2 (10) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR KAVINDER KUSTAGI 3001 HOSPITAL DR CHEVERLY, MD 30185 State 31. Data filled (Month, Day, Year) 32. Registrar's Signature.		spita nours nerel		29a. Certifier 1 Certifyi	ng Physician: To the best of	of my knowledge, dea	th occurred at the tir	ne, date and p	place, and due to the	cause(s)	and manner as	stated.	
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					Breen &	Spirit							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-09353 State of Maryland / Department of Health and Mental Hygiene Jeron Ford 1- For State Certificate of Death Registrar Date of Death 1. Decedent's Name (First, Middle Last) Physician/ 0030 hrs Medical Examiner Jeron D. Ford December 8, 2006 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Forrestville Prince George's Hampton and Darcy Road If Under 1 Year | If Under 24Hrs. 8. Date of 8irth(MM/DD/YYYY) 9 Birthplace (State or 5 Social Security Number 7. Age (In yrs last birthday) **Funeral** County sh, DC Months Days Hours 01 - 06 - 197927 Director 220-02-4383 1 Xivi 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State X Yes 2 No or items 23a or 28a-f show must be notified at once. PG Beltsville Director 10a. Citizen of What Country 10e. Street and Number 20705 11303 Big Horn Court USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8 lack 11. Marital Status 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married Married 2 X No Yes Black If Yes, Give Year Yes 2 X No specify: Specify Divorced Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 hment of Health and Mental Hygiene.

tant: If item 27 is marked other than "r
or other traumatic event, the Medical E Tow Truck Driver Private Industry 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Raymond Ford, Sr. Cecelia Mack Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) g $Horn\ Court$ le, $MD \cdot 20705$ 9b Mailing Address (Street 11303 Big Hobertsville, 19a Informant's Name/Relationship (Type, Print) ဥ Vanessa Ford, (Wife) Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) ▼Burial 2 Cremation 3 Removal from State permit. Pages
Department or
Important: Harmony Memorial 12-16-06 Landover, MD. Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Ralph Williams Funeral Service 1813 Potomac Ave., SE: Wash., DC 20003 Approximate Interval 26a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician 8etween Onset and failure List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö ģ Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? has performed? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: 26 Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient Other, ER/Outpatient DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes ² 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Dec 7, 2006 Driver auto fixed object collision 2325 hrs Natural Yes 2 V No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State)
Hampton and Darcy Road , Forestville, MD within 24 hours at To the Funeral D determined (Specify) Local Street Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

2 1

29b. Signature and title of certifier

Pamela E. Southall, MD

31. Date filed (Month, Day, Year, 2006

30. Name and address of person who completed cause of death (Item 23a)

rema

32. Registrar's Signature

ORIGINAL

Assistant Medical Examiner

and manner stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

December 8, 2006

			State of Maryland / Department of Health a 1 - State Registrar Certificate of Death	and Mental I	Hygiene Reg. No. 200	6 41316	
			Decedent's Name (First, Middle, Last)	2. Date of Month	f Death	3. Time of Death	
	Physici /Medic		Cecelia F. Floyd	Nov	. 29, 2006	5:40P M	
}.	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	of Death	4c. County of Dea	ath	
	£.		Southern Maryland Hospital Clinton 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under	04.05		Georges	
	Funeral		Months Days Hours	Min. 8. Date of (Month)	, Day, Year) 9. Bi	rthplace (State or Foreign Country) shington, DC	
	Director		Usual Residence of Decedent	Apr.	1,1920 Wa	snington, DC	
	yland sow at		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
	a-f st ified	cto	MD Prince Georges Largo			Yes 2□No	
	th the or 28a e not	Jire	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	Country?	
	23a ust b	Funeral Director	1077 Largo Road #202 20774		USA		
	er deg tems ner m	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Ori	igin? (Specity Yes o n, Puerto Rican, etc.	r No- 14. Race - Am Black, Wh		
36	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f show wht, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No If Yes, Give 1 ☐ Yes 2 ☒XNo Specify: 3 ☒ Widowed 4 ☐ Divorced Year or Dates:		Specify:	Black	
21215-0036	2 hou atura cal E	ed	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busines	s/Industry	
215	hin 7% In "na Media	Completed	(Specify only highest grade completed) (Give kind of work done during mos life. DO NOT use retired)	st of working			
21;	d wit	Š	12 Homemaker			Industry	
pu	tal Hy d oth	Be	(**************************************	er's Name <i>(First, Mic</i> anche Ho	ddle, Maiden Surname)		
Maryland	12 should be fill hand Mental H ris marked otl	은					
Mar	12 sh h and 7 is n traun		19a. Informant's Name/Relationship (Type. Print) Cecelia Ford (Daughter) 19b. Mailing Address (Street and Number 1 2 2 0 3 Horizon (Type. Print) The Washington	Court		Zip Code)	
	1 and Healt em 2	123	20a Method of Disposition 20b. Place of Disposition (Name of	MD. Date	2.0774 20c. Location - City of	r Town, State	
õ	ages ent of t: If It y or o		tended to the state of the stat	12/12/20	06 Suitla	nd, MD.	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natun any injury or other traumatic event, the Medical once.		21. Signature of Funeral Service Licensee Ralph William				
B	permi Depar Impor any ir		(alph & William 767 1813 Potomac	ns Funer AveSE	al Service : Washingt	on. DC20003	
	THE REAL PROPERTY.		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.			Approximate Interval Between	
18	Physician		Immediate Cause (Final disease or condition ATTARNOS CLEANE Candio Vand	ala Di	Gass	Onset and Death	
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Attenosclentic Cardio Van Due to (or as a consequence of): End the Reval Nistan			39.	
P	Examiner	L	Sequentially list conditions. b. Evol stage Renal Missian	_		59.	
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
	xecut and	xan	that initiated events resulting in death) Last C				
58760,	cate be executed physician and the burial-transit	dical	d				
Box	death certif e attending d for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of d	,	
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	o the vithin 2 o the comple	Med	, and manner stated.		29d. Date signed (Moi	nth, Day, Year)	
	Z Z Z 8	-	m (:1 _ M.O DU()	65	29d. Date signed (Month, Day, Year)		
	(II)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1 1	/.	
CK	- (1)		29b. Signature and title of certifier 29c. License number PLS7 30. Narte and address of person who completed cause of death (Item 23a) (Type, Print) Michael Cidalons M. II7al living Stan Rd # 4 31. Date filed (Month, Day, Year) 32. Registrar's Signature	101, font.	WASLington	MD 70 149	
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	Regist	rar	DEC 0 8 2006 / Jane 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** December 3:30 P M Robert Edwin Fox 2006 8, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) April 13, 1920 Pennsylvania Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 X M 2 ☐ F Months 173-07-1465 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits id 2 should be filed within 72 hours after death with the Marylan lih and Mental Hygiene. 27 is marked other then "natural", or Iteme 23a or 28e-f ehow traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Directo Cecil Maryland Perruville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18 Greenbank Court 21903 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 △Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Millwriaht Chemical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Fox Unknown ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Fox/Daughter 18 Greenbank Court, Perryville, MD 21903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12-12-2006 permit. Pages
Department of I
Important: If it
eny injury or o 1 ☐ Buriai 2 🛱 Cremation 3 ☐ Removal from State R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalum Juneral Service License 22. Name and Address of Facility T. Foard Funeral Home, P.A. 11 South Queen Street, Rising Sun. MD 21911 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list concilions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial .O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 known certificete has been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 14No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 2 No 1 Tes 1 Impatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Mann of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours effer To the Funerel Dire 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) enal) 32. Registrar's 31. Date filed (Month, Day, Year)

State

Registrar

DEC 1 1 2006

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygn Important: If item 27 ie marked eny injury or other to ance. **Physician** /Medical Examiner

Physician

/Medical

Examiner

Directo

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Be Completed

Funeral

Director

item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be multilad at

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

physicien and s the burial-transit To the Hospital or Attending within 24 hours after death.
To the Funerel Director: Aft

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner? 1	
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State

Registrar

istrar's Signature

11855 Holly Lane #107, Waldorf, MD 20601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Nalin Mathur, MD,

DEC 11

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

06-09257

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		4/10 Conway Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	ecedent of Hispanic Origin? (Sp	ecify Yes or No-	U.S.A.	ican Indian, Black,
ath w ast be	Funeral	1 Never Married 2 Married Armed Forces? If Yes,	specify Cuban, Mexican, Puerto		White, etc.	iodi i i i i i i i i i i i i i i i i i i
. or i		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Ye	es 2 No specify:		Specify: Wh	; tp
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7 ≈ ₽ = ₹		1 Burial 2 Cremation 3 Removal from State crematory or other	place)	112/06	,	
_ ⊑	1	4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Nam 22. Nam	CEMETERY 12/	12/00	E.N. Mark	et, Maryland
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/Medical		Contact Countries Mound of Hood				Between Onset and Death
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A STATE OF THE STA		Sequentially list conditions, b.				
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Division of Vital Records, rate after the law requirents are the after this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should be a should be	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	B DOA Other; Nursi	ng Home 5 F	tesidence 6 🗸 Othe	r: Scene
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를 잘 돌 흔		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred one) Medical Examiner: On the basis of examination and/or investigation				
To the within 2 To the complet	Medical	and manner stated.	29c. License number		29d Date signed (Mo	
	2	29b Signature and title of certifier	O.C.M.E.		December 6, 20	
		/ peodor M. My JR, mus,	O.O.IVI.L.			
		30 Name and address of person who completed dedse of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 1	11 Penn Street, Baltimor	e, MD 21201		
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Regist		DEC I I FORD SPENS IN PARTY	ν <u> </u>			

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		For Stete	State of Maryland	I / Department of Health and M Certificate of Death	/ UUb	41321
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Р ,		Usual Residence of Decedent 10a, State 10b, County	10c City	Town or Location		10d. Inside City Limits
anyla shov	5	10a. State 10b. County	, ioc. oxy	Town of Eboation	*	1 ☑Yes 2 ☐ No
he M	Director	10e. Street and Number	ot /	10f. Zip Code	10g. Citizen of What C	Country?
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Maryland 21213-UU36 d 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. 27 Is marked other than "natural", or Items 23a or 28a-1 show traumatic event. It a Modical Examinational be natified at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Busines	s/Industry
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W - T		20a. Method of Disposition	Ca		Date 20c. Location - City of	or Town, State
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Baltimo permit. Page Department Important: If any injury o		21. Signature of Funeral Service Lice	nsee O/ O	22. Name and Address of Facility HENRY FUNERAL HOM		,
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		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line:	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
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ted	nln	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 (0. 20 2 00.0040			
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68 iffical g ph	Completed by Physician/Medi	IS SELLALS				
Box eath cert attendin for use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		23d. Date of d Month	elivery Day Year
the dea y the at ached fo	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	ath 5 Other (specify)	Worth	Day 13a1
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		30. Name and address of person who	completed cause of death (Item			
				174 Kings Wood Drive, E	aston, MD 21601	
5	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure		
Regi	strar	DEC 0 7	2006	1. foods		

Amen d #19b Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per FH State of Maryland / Department of Health and Mental Hygien [] [] 12/13/06 PGC hh Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dec. 6, В. Elsie Gasch 2006 3:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12319 Stonehaven Lane # T-21 Prince George's Bowie 8. Date of Birth (Month, Day, Year) Mar. 15, 1 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax **Funeral** Days Min Months Hours 1 □ M 2 🕱 F Yrs. 577-32-7139 80 1926 Bowie, Md. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show ir than "natural", or itema 23a or 28a-f ehow The Madical Examiner: ust be notified at 1 XYes 2 No Director MD Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 12319 Stonehaven Lane 20715 USA # T-21 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Govt. / NSA Administrator Pages 1 and 2 should be filed vent of Health and Mental Hygicint: If Item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dorothy King John Berbig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2742 Aliver Ave. Oakland, CA Carl Gasch / Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. Veterans Cemetery 12/15/2006 | Cheltenham, MD. 4 ☐ Donation 5 ☐ Other (Specify) MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760 death certificate be Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. detached 9☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus type 2 certificate has autopsy Peripheral vascular disease 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 res 2 No Hospital: 1 Inpatient 2 ER/Outpatienl 3 DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funerel Director: After 1 Natural 5 Pending investigation 2 No 1 Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059633 08 200G ind address of person who completed cause of death (Item 23a) (Type, Print) Glen/Jacob, M.D. 1221 Mercantile Lane Largo, MD. 20774 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 2 2006 Registrar

		-	FOR	Department of Health and N Certificate of Death	Mental Hygier	ZHHb 31323			
2.	- 8g/%	7	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death			
3,	Physicia		Gloria S. Goodman		December	4, 2006 10:30A M			
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
**	LAUTHIT	âr.	8427 Grand Haven Avenue	Upper Marlboro	P	Prince Georges			
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birt	1 1/11 1 0/11/2	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)			
100	Director		011-42-8171 1□M 2⊠F 64	Yrs.		1941 Hondorus			
	p ,		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town	or Location		10d. Inside City Limits			
	anyla show	2				1X Yes 2 ☐ No			
	788-f	Director	Maryland Prince Georges Upper M	Iarlboro	10g.	Citizen of What Country?			
	with a or	ă	8427 Grand Haven Avenue	20772		Inited States			
	72 hours after death with the Maryland natural; or Items 23a or 28a-f show ocal Examinet must be notified at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S		14. Race - American Indian,			
	ter d	'n	Armed Forces? 1 □ Never Married 2 ☒ Married 1 □ Yes 2 ☒No	If Yes, specify Cuban, Mexican, Puero	Rican, etc.)	Black, White, etc.			
38	al', or	by I	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black			
21215-0036	2 hou	ted		Decedent's Usual Occupation (Give kind of work done during most of work	king 16b	. Kind of Business/Industry			
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Baltir	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	ope Funera 538 Marlbo orestville	al Homes pro Pike e. MD. 20747			
7	4, 9		23a, Part1. Enter the disease or complications that caused the death. Do			Approximate			
i i			shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death			
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Θ,	s tha	by P	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		co use contribute to the cause of death?			
ĕ	w require been sig should b				1 🗆 Yes	2 ☐ No 3 ☐ Probably 4 ☒ Unknown			
Vital Records,	law requas been 2 should	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
æ	0 - 0	Eo			performed	death?			
ta	an: Th tificete tor, pag	a	25. Was case referred to medical	26. Place of De	ath (Check only one)				
\geq	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3 DOA Other: 4 Nursing H	lome 5⊠ Residenc	e 6 ☐Other (Specify)			
J Of	ding Ph h. After th funeral		(Manth Carl Voor)	Time of 28c. Injury at Work?	28d. Describe how i	injury occurred			
jo		atio	2 Accident investigation	M 1 Yes 2 No					
Division	2 # E	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)			
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledgy 2 Medical Examiner: On the basis of examination ar and manner stated.						
	Fo the vithin Fo the complete	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)			
	-		I SHO MID	D41762		12/08/06			
	6		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		12/08/06 300, 1:100x SANWG			
	4		TORN V. GOLDEN 1400 FOR	EST GLEW NOAD	JuiTE.	300 SILVER SANNE			
- 3-(1	St	ate	31. Date filed (Month, Day Year) SEC 08 2006 32. Registrar's Signature.	1		1000000			
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.	To Be Completed by Funeral Director	1 4: 5. U 1: 1 1
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		For State	State o	of Marylan				nd Me	ental Hy	giene	0000	7 1	0.01
	-	Registrar 1. Decedent's Name (First, Middle, I	Last)		Ce	rtificate d	or Death		2. Date of De	Reg. No	2006	3. Time	of Death
Physicia		0 11 1	nn	Garrab	rant			١.	Month	7 ,	Year 2006	8:30	D 11
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Funeral Director		5. Social Security Number 6. 220–42–0009	.Sex 1	7. Age (In yrs. 1	V	If Under 1 Ye Months Da		Min.	8. Date of Bir (Month, Da	ay, Year,	Co	iplace (State untry)	
Jiiector		Usual Residence of Decedent		0.2)				0ct.16	,194	+l Ma	ryland	
tat	3	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside	•
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al Hyg	Be C	17. Father's Name (First, Middle, La	st)				18. Mother	's Name	(First, Middle	, Maider	n Surname)		
Menta arked atic e	To	Robert B. Garrab							h Ady				
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship		. 1							or Town, State, Z	ip Code)	
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oartm sortar / Injur		21. Signature of Funeral Service Lic		1			Idress of Facility				Home	L, Mar	yrand
an an an		James Ch	3/6		1						h., D.C.	2000	7
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 X Certifying	Physician: To the	e hest of my kno	wledge deat	h occurred at th	e time date and	Inlace a	nd due to the	caucole	s) and manner as	atata d	
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To the comp	Me	29b. Signature and title of certifier	0	4	۱۸۸۸		ense number			29d. Da	ate signed (Month	, Day, Year)	
2		A	nol	VOIR	VVV	D00	53615		I	Dece	cember 11, 2006		
		30. Name and address of person wh					#200 B	1 '	11- 1	(D) 2	0050		
Sta	te	Aruna S. Nathan		11125 Ro Registrar's Signa		re Pike	#ZUÖ KO	OCKVI	ттте, М	уш) 2	U852		

DHMH 17 Rev 1/2001

State

Registrar

DEC 12 2006

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of		Mental Hy	giene Reg. No:	'IIIIh	413	25
	Physicia		1. Decedent's Name (First, Middle, Last, Becca Jane Geiger)				2. Date of De Month	eath Day	Year	3. Time of	
	/Medic	al .	4a. Facility Name (If not institution, give	etroot and number)		4b. City, Town, o	r Location of Dea	Decembe		2006 County of Death	2:00	P M
	Examin	er	Country Meadows As		ving	Frede		201	10.	Freder		
	Funeral		Social Security Number 6. Se		(In yrs. last birthda)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, D.	ay, Year)	9. Birth Cou	nplace (State o	ir Foreign
	Director		234-42-5560 Usual Residence of Decedent	JW 288.F	80 Yrs.			Ocy. 1	6, 19	926 West	Virgi	nia
	yland		10a. State 10b. County		10c. City, Town or I	ocation					10d. Inside Ci	
	Ba-f el	ctor	Maryland Frederi	ck	Frede	erick					1 🗌 Yes	2 🔯 No
	with th	Funeral Director	10e. Street and Number	ı D 1		10f. Zip Code 217	0.7			zen of What Coi ited St	1	
	me 23	erai	5955 Quinn Orchard	12. Was Decedent I	Ever in U.S. 13	. Was Decedent of H		Specify Yes or N		14. Race - Amer	ican Indian,	
9	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f ehow Jical Examiner in unt be netified a	/ Fur	1 Never Married 2 Married	Armed Forces? 1 ⊠Yes 2 □ N If Yes, Give	l°1951 –	If Yes, specify Cub		erto Hican, etc.)		Black, White Specify: Wh	netc. nite	
21215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Edu	Year or Dates:	1956	edent's Usual Occur			16b Ki	nd of Business/l	ndustry	
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ary!	should nd Me mark mark	၉	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Ma	ling Address (Street	and Number or I	Rural Route Numb	er, City o	r Town, State, Z	ip Code)	
Ž	and 2 alth a 127 le		Desiree Earle / Da	ughter	20 3	Young Bran	nch Dr.,	Middlet	own,	MD 2176	59	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Madical Examinational be incliffed a once.		20a. Method of Disposition 1 ☐ Burial 2 ☆ Cremation 3 ☐ F	Removal from State	20b. Place of Dis cemetery, cr	position (Name of ematory or other pla	Dece	ember 12,		cation - City or 1		
Ħ	it. Partmen artmen ortent: injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Final Service License			n Cremato		2006		erick,		ıd
Ba	Depa Impo any l) ///			22. Name and Addre esthaven 501 Catoc						
			23a. Part1 Enter the disease, or comp chock, or heart failure. List only o	lications that caused ne cause on each lin	the death. Do not e						Approximat Interval Bet	ween
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	/Medical Examiner		1930tting in doutry	Due to (or as	a consequence of):							
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9	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical		o,					1			
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о: П	at the dea by the at tached fo	ysici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify) _				Wichin	Duy	1041
<u>α</u>	g g g	by Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did	tobacco u	ise contribute to	the cause of c	jeath?
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DIV	after deat after deat Director: d in by the	Certification;	4 Homicide determined	building, et		street, factory, office		City or To	wn, State)	ALL FIGURE 14411	Der,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in the Funeral C	Medical C		iner: On the basis of	of my knowledge, de f examination and/or							3)
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	M		1/am		in	D	41866		Dece	mber 11	, 2006	
11	HIVE		30. Name and address of person who o								Y	ì
	. ,		Kanan Hudhud, M.D	46 B Tho	omas Johns	on Drive,	Frederi	ick, MD 2	21702			
	Sta Regist		31. Date filed (Month Pax Year) 2	UU5	ar's Signature	goods						

			1 - For State Registrar	State of Maryla			nt of H			giene 0 0	16 4	1326
100	Dhusia		1. Decedent's Name (First, Middle, Las	t)			···		2. Date of Dea Month	ith		Time of Death
1	Physic /Medi		RUTH MILDRE	D GODWIN						ER 15,	Year 2006	5:15P M
1	Examir	ner	4a. Facility Name (If not institution, give	street and number)		4b. Cit	y, Town, or	Location of [4c. County		
			WALDORF HEA			14 1 1 2 4	WAL	DORF If Under 24	Hen I a		RLES	
	Funeral Director			2X F 90	s. last birthday) Yrs.	Months			Min. 8. Date of Birth (Month, Day	, Year)	9. Birthplace Country) VIRGI	(State or Foreign
	Maryland	tor	10a. State 10b. County MARYLAND CHAR		City, Town or Lo							nside City Limits
	r 288	Director	10e. Street and Number				ip Code			l0g. Citizen of W	hat Country?	
	th wit	a D	4140 OLD WASHI	NGTON ROAD			206	01		τ	J.S.A.	
980	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f show disal Examinat must be codified at	by Funeral	11. Marital Status 1 Never Married 2 Married XXVidowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			edent of Hisecify Cubar		? (Specify Yes or No- uerto Rican, etc.)	14. Race Black	- American In x, White, etc. WHITE	ndian,
Maryland 21215-0036	be filed within 72 hours ital Hygiene. Id other than "natural", event, the Medical Exa	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	kind of w DO NOT	use retired)	urina most of	f working	16b. Kind of Bus	siness/Industr	у
22	filed v Hygie ther t		12 17. Father's Name (First, Middle, Last)		HOME	MAK		40 14-41	N = 457 + 44144	OWN F		
ryland		To Be	John B. JONES				A.A.	ELS	Name (First, Middle, IE QUILLE)	EN	, 	
Ma	12 e 1 e 1		19a. Informant's Name/Relationship (T)		The second second				or Rural Route Number			
Baltimore,	ss 1 a of Hei Item othe		PATRICIA WILLIA 20a. Method of Disposition 1 X X rial 2 Cremation 3 Cremation 3 Cremation 3 Cremation 3 Cremation 3 Cremation 3 Cremation 3 Cremation 3 Cremation 3 Cremation 3 Cremation 3 Cremation 3 Cremation 3 Crematical Property Statement	Removal from State	cemetery, crei	natory or	ame or other place	9)	Date	20c. Location - (City or Town, S	State
Ħ		H	4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		ONING			X Y │	2-20-06	OAK HI	LL, V	A
Ba	permit. Depart Imports any inj		23a. Part 1. Enter the disease, or comp	0.1	R	AYM	I DNC	TUNER	AL SERVIC		•	
	Physician /Medical Examiner	iner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. CARD Due to (or as a conse	QUAC quence of): Sehe		X R R	レイエ	HMIA LEART 1		HR.	roximate rval Between set and Death
D. Box 68760,	is death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical Examin	that initiated events resulting in death) Last	Due to (or as a consected. 23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of a	ancy al death 3	Ectopic (oregnancy			23d. Date Mont	of delivery h Day	Year
P.0.	res that the de signed by the a i be detached f	Ph	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the u	derwing	esues awar	in Part I	22a Did tak	acco use contrib		
ords,	The law requires that the ste has been signed by the bage 2 should be detache	sted by	DEMENTA	·	Sutting in the u		cause giver	Harran,	T	s 2 No 3		
Division of Vital Records,		Completed by							24a. Was an autops perform	y pri ned? de	ere autopsy fir or to completi ath? Yes 2 1	ndings available ion of cause of No
5	Physician: r this certifice ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ ♣io	lospital:	7500		Other		Death Check only on		-	
of	Phy or this aral d	2:10	27. Manner of Death	1 Inpatient 2	ER/Outpatien 28b. Time of		UA	4 Nursir	g Home 5 Reside			
<u>o</u>	nding tth. r: Afte	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	28c. Injury : Work? 1 🔲 Y	es 2 No				
Divis	To the Hospital or Attending Physician: while 24 hours after death as the teath To the Funeral Director. After this certifical completely filled in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre fy)	eet, factor	y, office		28f. Location (Sti City or Town	reet and Number , State)	or Rural Rou	te Number.
	he Hospi n 24 hou he Funer sletely fill	edical	29a. Certifier 1 ertifyin Phyone) 2 Medical Exami	sician: To the best of my known. On the basis of examination and manner stated.	nwledge, death ation and/or inv	estigation	at the time n, in my opin	i, data and pl nion, death o	accurred at the time, da	idse(s) and mani ite and place, an	d due to the c	cause(s)
	To the within 2. To the complete		29b. Signature and title of certifier	1		29	c. License	number	29	d. Date signed (Month, Day,	Year)
		1	30. Name an hardress of person who co	empleted cause of death (Iter	n 23a) /T				136 J			2006
	3		ASHVINKUMAR	J PATEL	NS) (Type, I				ELION CT			D 20600
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature doe	1					-, -,	

			1 - For Stata Registrar	State of Ma	aryland / Dep <i>Ce</i>	artmen <i>rtificat</i>					iene	006	413	127
	Physici	an	Decedent's Name (First, Middle, Last)							2. Date of Deat Month	h Day	Year	3. Time of	Death
	/Medi			Anna Gil	boyne					December	19,	2006	2212	РМ
1	Examir	ner	4a. Facility Name (If not institution, give :	street and number)				Location of	of Death			ounty of Death		
	Funeral		Union Hospital 5. Social Security Number 6. Sex	7. Age	e (In yrs. last birthday)	If Under	kton 1 Year	If Under	24 Hrs.	8. Date of Birth	(Cecil	nlana (State or	r Foreign
	Director			M 2₹F 9		Months		Hours	Min.	JAN 15,	^{Year)} 1915	Penr	place <i>(Stat</i> e o <i>r</i> ntry) ISy1van	ia
	D .		Usual Residence of Decedent											
	show	_	10a. State 10b. County		10c. City, Town or L								10d. Inside City	
	the M	Director	Maryland Cecil 10e. Street and Number		Rising		-						1 🗆 Yes	2 M 140
	with a or			Oned		10f. Zip				1	-	n of What Cou	•	
	ours after death with the Maryla ral', or Items 23a or 28a-f shov Examiner must be notified at	Funerai	1881 Telegraph I	12. Was Decedent I	Ever in U.S. 13.		911 dent of Hi	spanic Ori	gin? (Sp	ecify Yes or No-		ted Sta		
9	or Ite	T.	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 💢 N	lo				i, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	etc.	
23	hours after death with the Maryland tural', or Items 23a or 28a-f show al Examiner must be notified at	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2X No	Specify:			S	рөс <i>ify:</i> Wh	ite	
5	n 72 hours "natural", adical Exe	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usua kind of wor DO NOT us	rk done a	lurina mos	t of work	ing	16b. Kind	of Business/In	dustry	
12	within ene. then	E C	Elementary/Secondary (0-12)	College (1-4or 5	+)	memak		,			Tr	Her O	an Home	2
9	Hyg other	Be C	17. Father's Name (First, Middle, Last)		110	memare		18. Mothe	r's Name	e (First, Middle, N			WII IIOIIIC	,
'lan	uld be Aenta rked tic ev	To B	Howard Conway				ŀ	A	nna	Henry				
Maryland 21215-0036	sho and h		19a. Informant's Name/Relationship (Ty)	·-	19b. Maili	ng Address	(Street a	and Numbe	r or Run	al Route Number,	City or T	own, State, Zip	Code)	
	and and m 27		Raymond J. Gilbo	oyne/Son				-	- 10	North Ea	ast,	Maryla	nd 2190)1
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Deportment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natur any hijury or other traumatic event, the Madical any files.		20a. Method of Disposition 1 ↑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of Dispo cemetery, cre-	osition (Nan matory or o	ne of ther place	9) I	Dece	nber 2	Oc. Loca	tion - City or To	own, State	
Ë	t. Partmen		4 ☐ Donation 5 ☐ Other (Specify)		Laurel M				23, 2		Pomoi	na, New	Jerse	у
Ba	Deperment of the population of		21. Signatule of Funeral Service License	00	— H ²	cks h	d Addres Iome	for [y Fune:	rals, P. eet, Elk	Α.			
	_		23a. Part1. Enter the disease, or compli	cations that caused	the death. Do not en	or the mod	Stoc e of dvino	kton	Str	eet, Elk	ton,	Maryla	nd 219	21
	Physician		Immediate Cause (Final							,,			Interval Betw Onset and D	veen
	/Medical		disease or condition resulting in death)	Due to (or as	consequence of):	arche	~ -	900	re					
ш	Examiner		Cognostiathy list conditions h		Kalinia								12 4	1015
9.	ם ב	ner	Sequentially list conditions, in any, leading to internediate cause. Enter Underlying Cause (Disease or injury		a consequence of):									
3	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or or										
8760,	ate be executed physicien and the burial-transit	E		Due to (or as a	a consequence of):									
687	ficate physis the	edicai	d											
Box (leath certifica ettending ph for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome							230	d. Date of delive	arv	
-	death e ette	Icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at		Ectopic pro Other (spe						Month		ear
P.O.	at the by th	hys	9 □ Unknown	9 Unknown						1				
	The law requires that the death certific ste has been signed by the ettending p page 2 should be deteched for use as		Part II. Other significant conditions con			nderlying ca	ause give	n in Part I.		23e. Did tob	acco use	contribute to the		ath?
oro	w requir been si should	ted	Corogen arter	y dist		•				1 🗌 Ye	s 2/Q1	3 ☐ Prob	ably 4 □Ur	nknown
3ec	The law sete has b page 2 s	Completed by	CUA - WITH	residu	al Rts	rde	W	es lou	001	24a. Was an autopsy		24b. Were auto prior to co	psy findings a mpletion of cal	vailable use of
a			_	<u> </u>						perform 1 Yes 2	346	death? 1 ☐ Yes	2 No	
Κ	Physician: this certifical al director,	o Be	25. Was case referred to medical examiner?	ospital:			Othe	r		(Check only one				
o	Phy ar this eral d	n; To	27. Manner of Death	1 Inpatier 28a. ate of Injur	y 28b. Time o		Bc. Injury Work	4 🗀 1901		ne 5 Resider 28d. Describe hov			y)	
ion	ath. r: Afte	atio	1 Anatural 5 Pending 2 Accident investigation	(Month, Day	Yea <i>r)</i> Injury	м		? 'es 2 □ N	No					
Division of Vital Records,	er de recto by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, farm, str	eet, factory	, office			28f. Location (Str. City or Town,	eet and N	lumber or Rura	l Route Numb	16 <i>1</i> ,
	ital o													
	To the Hospital or Attending Physician: Within 24 hours eller death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medicai	Check only 2 Medical Examin	er. On the basis of	f my knowledge, deatlexamination and/or in	n occurred a	at the time	e, date and	d place, a	and due to the car	use(s) an	d manner as st	ated.	
	ithin 2 of the omple	Med	29b. Signature and title of certifier	and manner sta	ted.		License					igned (Month,	<u> </u>	
	F≯∓8		1416/			i			5 A	1		uber Z		76
	1-	1	30. Name and I dress of person who col	noieted cause of de	ath (Item 23a) (Type			519					s, en	, 0
	40		Alfred APINO	W1001	06 Bow	Stre	+	Elkt	24	40 2	1921	1		
	Sta		31. Date filed (Month, Tay Year) 7 2	06 32. Registra	r's Signature	carle)	1	- '	7	40 2	-			
	Registr	ar		30	4									

mory Gilboyue

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Decedent's Name (First, Middle, Last)

WASHINGTON Birthplace (State or Foreign
Country) MARYLAND 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. WHITE 16b. Kind of Business/Industry CONSTRUCTION 20c. Location - City or Town, State HAGERSTOWN MARYLAND Approximate Interval Between Onset and Death 1 Day 3 Months 3 Months. 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 ☐ Yes

3. Time of Death

7:50P.M.

Year

Specify

29d. Date signed (Month, Day, Year)

301-432-8470

Dec. 14, 2006

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

GHAZALA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29c. License number

1) 46561

			1. Decedent's Name (Fi	irst, Middle, La	st)						2	Date of De			3. Time o	f Death
ь	Physici		JAMES	В.	HAWK	INS,	SR.				Г	DEC.	08 Pay	2006 Year	5:30	Мф
1	/Medio Examin		4a. Facility Name (If not	institution, giv	e street and number))		4b. City, To	own, or	Location of	Death			County of Death		
)	LXamii		SOUTHERN	MARYI	LAND HOSI	PITAL		CLI	NTC	N			PR	INCE G	EORGE	S
	Funeral		5. Social Security Numb	oer 6. S	ex 7. Ag	ge (In yrs. las	t birthday)	If Under 1	Year	If Under 24		B. Date of Bi	rth		place (State ontry)	
П	Director		579-64-05	83 1	™ 2□ F	58	Yrs.	Months	Days	Hours	Min.	(Month, Di	–194:	8 WAS	$\overset{ntry)}{\mathrm{H}}$ DC	
	D		Usual Residence of Dec	cedent					1					.,,,,,,,		
	ylan Jow at		10a. State 10	b. County		10c. City,	Town or Lo	cation			1				10d. Inside C	ity Limits
	A-f s	Director	MD P	RINCE	GEORGES	CA	PITO	L HEI	GHI	'S	4				1 □X Yes	2 □ No
	r 28%	ire	10e. Street and Numbe	r	· · ·			10f. Zip C	ode			-	10g. Citiz	en of What Cou	ntry?	
	h wit 3a o st be		1038 KA	REN BI	LVD.			2	074	.3			1	U.S.A.		
	ms 2	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S.	13. \	Vas Decede f Yes, specif			n? (Speci	fy Yes or No		4. Race - Ameri		
9	after or ite nine	Ŀ	1 X Never Married	2 Married	Armed Forces?			r ves, specii 1 □ Yes 2[Puerto Ri	can, etc.)		Black, White		
8	ral", c	by	3 ☐ Widowed 4 ☐	Divorced	If Yes, Give Year or Dates:			I∟ Yes 2l	≛ PNO	Specify:				Specify: BL	ACK	
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	ted	15.	Decedent's Ed	ducation ade completed)	Ţ	16a. Deced	dent's Usual kind of work	Occupa	ation	of warking		16b. Kin	d of Business/Ir	ndustry	
2	within 7 ene. than "i he Med	Completed	Elementary/Secondar		College (1-4or	5+)	life. L	DO NOT use	retired))	JI WUIKIIIG					
2	d wil	5	12				TRU	JCK D	RIV	ER_			P	RIVATE		
p	e filed al Hygi other vent, t	Be (17. Father's Name (First	st, Middle, Last)				1	18. Mother'	s Name (First, Middle	, Maiden S	Surname)		
<u> a</u>	should be nd Mental marked (matic ev	2	WALLACE	F	IAWKINS					MAD	GELI	NE	Bl	ROWN		
ary	should and Men s marke umatic		19a. Informant's Name	/Relationship (Type. Print)		19b. Mailin	ng Address (Street a	nd Number	or Rural I	Route Numb	er, City or	Town, State, Zi	c Code)	
Σ	alth a		JAMES B.	HAWK]	NS, JR.	-	1038	KARE	N B	LVD.	, CA	PITO	L HE	IGHTS,	MD 2	0743
ē,	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 271s marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Ì	20a. Method of Disposit			20b. Plac	e of Dispo	sition (Name	of		Dat			ation - City or T		
E	Pages nent of I ant: If ite ary or o		1 ⊈ NSurial 2 □Ci 4 □ Donation 5 □		Removal from State	RESU	JRREC	CTÍON	CE	M. 1	2-18	-06	CLI	NTON,	MD.	
Baltimore, Maryland 21215-0036	그 본 원 중		21. Signature of Funer										र हाए	NERAL I	HOME	
ñ	permi Depa Impo any ir		* /5と		hulps									WASH.		0001
	35.55		23a. Part1. Enter the d shock, or heart fa	isease, or com	plications that cause	d the death.	Do not ente	er the mode	of dying	g, such as c	ardiac or	respiratory a	rrest,	W11011	Approximat	te
*	Dhysisian		shock, or heart ta		one churle on each li	ne.	1061	1 (Oct	20010	C C 111	20	1	2-1	Interval Bet Onset and	tween Death
1	Physician /Medical		disease or condition resulting in death)		a. Due to (or as	1012121	217 051	C Cr	1000	SICULIA	200		HCCI	DEN!		
	Examiner				Due to (or as	WAGU	110 0	ATUV								
D.		F.	Sequentially list conditi-	ons,	b. Due to (or as		nce of):				_					-
	nsit	in	Sequentially list condition if any, leading to immediate. Enter Underlyin Cause (Disease or injury)	ng ry	CiR	RHOSI		of	41	VER						
	al-tra	Examiner	that initiated events resulting in death) Last		c. Due to (or as			21								
9	be e															
Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	cian/Medical			d											
X	certi nding ise a	Ž	IF FEMALE: 23b. Was decedent pre	gaaat	23c. If yes, outcome	e pf pregnanc	y						25	3d. Date of deliv	en/	
ŏ	eath atter for u	ciar	in the past 12 mor	nths?	1□Live birth 4□Pregnant a			Ectopic pred Other (spec						Month		Year
P.0.	w requires that the d been signed by the should be detached	Physic	1 ∐ Yes 2 ∐ No 9	0	9□Unknown			2 - 111-1 (0,50)								
	that ed by deta		Part II. Other significar	nt conditions	ontributing to death b	out not resulting	ng in the ur	nderlying cau	se give	n in Part I.		23e. Did	tobacco us	e contribute to	he cause of o	death?
ds	sign d be	d by										1 🗆	Yes 2□	No 3□Pro	bably 4	Unknown
Ö	requ	Completed														•
3e	ne law has l	du										24a. Was	psy 🍃	24b. Were auto	opsy findings impletion of c	available ause of
E F		S										1□ Yes	2 No	death?	2010	
Vit.	Physician: The k this certificate har ral director, page 8	Be	25. Was case referred examiner?	to medical	Hognital: >				Otha		of Death (Check only	one)			
J.	chysical this call din	은	1 ☐ Yes 2 No		Hospital: Inpation			t 3 DOA		4 🗆 Nurs				□Other (Speci	fy)	
ב	ing F	:uo	27. Manner of Death 1 Natural 5	Pending	28a. Date of Inju (Month, Da	ury 29 ay Year)	8b. Time of Injury		. Injury Work			d. Describe	how injury	occurred		
sio	Attending r death. ector: After by the fune	cati	2 Accident	investigation Could not be				M		res 2 □ Ne	0					
Division or Vital Records,	or Atter dufter du Direct	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	determined	20e. Flace of III)	jury - At home tc. <i>(Sp</i> ec <i>ify)</i>	e, farm, stre	eet, factory,	office		28	f. Location (City or To	Street and wn, State)	Number or Rur	al Route Nun	nber,
	ital curs afral curs afral D			/												
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1	Certifying Ph Medical Exar	ysician: To the best niner: On the basis o	of my knowle of examination	edge, death n and/or in	n occurred at vestigation, i	the tim	ne, date and pinion, death	place, an	d due to the	cause(s) a	and manner as : place, and due !	stated. o the cause(s	s)
	the hin 2, the l	Ned	one)	MAI	and manner st	tated.								1	`	
	5 × 6 × 6 × 7 × 6 × 7 × 9	2	29b. Signature and title	of cortifie	0.0			290.					29d. Date	signed (Month,	Day, Year)	
,			7	YVIII	M					, , , , , , , , , , , , , , , , , , , ,			12	11/10	NU 6	
	151		30. Name and address			death (Item 2	3a) (Type,	Print) A	re l	Son L	12.2	C	NITO	V MS	725	7-25
//~		- 1	VENTAT.	C. KI	AM AWAN	7501	SUK	101/1	> 10	CHO!	7 >01		110001	-		())
			ASJA			1	7 - 1					^				
	Sta Registr		31. Date filed (Month, DEC 1	Day, Year)		rar's Signatur		,	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg, No. 2 0 0 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** December 07 2006 /Medical tity Name # not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 8/Date of Birth (Month, Day, JULY 20 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 № M 2 🗆 F Months Days Hours Min. 1982224-27-4827 WASHINGTON, DC Director 24 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director PRINCE GEORGE'S FT. WASHINGTON 1 XYes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö be 20744 U.S.A. 2015 BELFAST DRIVE "natural", or items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: Specify: AFRICAN AMERICAN Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE PARALEGAL ASSISTANT 11th d 2 should be filed w th and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DEBORAH HARROD REGINALD YOUNG ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 partment of Health a portant; If Item 27 is / Injury or other trau 2015 BELFAST DR. FT. WASHINGTON, MARYLAND 20744 DEBORAH MCGIRT/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important; If any Injury or RESURRECTION CEMETERY 12/13/2006 CLINTON, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease shock, or heart failure. L e, dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Listonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Rainheria /Medical Due to (or as a consequence of) Examiner tra cene Successful list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar Due to (or as a consequence of): physician Physician/Medical the as 1 IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t page 2 s autopsy performed' certificate 2 ☐ No 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2□ No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA ဥ After this funeral 27. Mapner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural (Month, Day Year) Iniun 1 ☐ Yes 2 ☐ No 2 Accident death. hin 24 hours after death the Funeral Director; the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

Box 68760. the death certificate be P.O. Division or Vital Records, The Physician; or Attending

Saltimore, Maryland 21215-0036

Hospital 2 State Registrar

31. Date filed (Month, Day, 2006 12

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

32. Registrar's Signature

LISTOS LAZARIDIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

OHMS

29c. License number

29d. Date signed (Month, Day, Year)

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			1- State of Maryland / Department of Health and M Certificate of Death	•	giene Reg. No. 006	41331
			Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
1	Physici /Medio	al	STEPHEN SOOKIL HYUN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	DEC.,	10, 2006 4c. County of Death	7:40A ^M
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	Funeral Director		348 32 8840 X M 2 F 91 Yrs. Months Days Hours Min.	8. Date of Bird (Month, Da NOV 1	y, Year) Cou	place (State or Foreign ntry) KOREA
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	h with th	al Director	10e. Street and Number		10g. Citizen of What Cou	ntry?
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Ba	permit. Page Depertment of Important: If any injury or ance		21. Signature of Fineral Service and Address of Facility CF		HINDS FUN MARLBORO N	
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27. Manner of Death 1	1
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2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route City or Town, State) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye)	
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye	ır)
D23308 DECEMBER 10, 200	6
30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print)	
VICTOR M. PRIEGO, MD, 6420 ROCKLEDGE DR #1400, BETHESDA, MARYLAND 20817	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 1. Date filed (Month, Day, Year) 32. Registrar's Signature	

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Depertment of Health and Mental Hygiene "natural", or itams 23a or 28a-f show important: if Item 27 is marked other than "natural", or itams 23a or 28a-f show any Injury or other traumatic svent, the Medical Exemples must be publised at once.	1	1	of Disposition			20b. P	lace of Dispo					Date	20c. L	ocation -	City or T	own, State
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			. For	State of Maryland				•		
			1 - State Registrar	·		tificate of			g. No. 2006	41334
	Physici	an	1. Decedent's Name (First, Middle, Lat	HAAC				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, giv.	e street and number)		4b. City. Town, o	r Location of Death	YELEMAG	4c. County of Death	
	Examir	lei	HEBREW HOME OF G		N		CKVILLE		MONTGO	
	Funeral		5. Social Security Number 6. S 139–10–9637	C C -	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JAN 18,	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	2. 9.	113.			JAN 18,	1912 NEW	ĴÉRSEY
Maryland	a-f ehow	ctor	10a. State 10b. County MARYLAND MOI	NTGOMERY 10c. City,	Town or Lo		CKVILLE			10d. Inside City Limits 1 XYes 2 □ No
th with the	23a or 28 ust be no	Funeral Director	10e. Street and Number 6121 MONTROSE RO	AD		10f. Zip Code	20852	10	g. Citizen of What Cou	ntry?
5-0036 72 hours after death with the Maryland	al', or items 23a or 28a-f ehow Examinar must be notified at	É	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub. I ☐ Yes 2€ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: W	
Maryland 21215-0036	e. Aedical	Completed	15. Decedent's E. (Specify only highest gra	ducation ide completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of worl	sing	6b. Kind of Business/Ir	ndustry
d 21	Da		12			SALES				ETICS
and	d a	Be.	17. Father's Name (First, Middle, Last) HARRY SORIN				18. Mother's Nam BERTHA K	e (First, Middle, M. ΔΤ7.	aiden Sumame)	
aryla	marke umatic	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street			City or Town, State, Zi	o Code)
	f Health a Item 27 Ic		MARLENE LIPMAN,		and the same				NEW YORK	10023
Baltimore,	っここ		20a. Method of Disposition 1 Burial 2 □ Cremation 3 The state of the state of	Removal from State	etery, cren	sition (Name of natory or other place	ce)		0c. Location - City or T	
Iltir		1	4 Donation 5 Other (Specifical Signature of Specifical Control of			A second second second second			SELIN, NEW	JERSEY
Balt	Deper Impor		(((((((((((((((((((ED 10	WARD SAGI 91 ROCKV	ss of Facility EL FUNERA LLE PIKE	L DIRECTI . ROCKVII	ON, INC. LE, MARYLA	ND 20852
E	nysician Medical xaminer	ner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	plications that caused the death. one cause on each line. Due to (or as a conseque) Due to (or as a conseque)	SON AL	1'5 D.	ng, such as cardiac ISEAS RTEN	E		Approximate Interval Between Onset and Death
: 68760, rtilicate be executed	ng physicien and as the burial-transit	Medicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	nce of):					
Records, P.O. Box 68 The law requires thet the death certifica	by the attending phy tached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months 1 Yes 2 1100 9 Unknown	33. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3	Ectopic pregnancy Other (specify)	,		23d. Date of deliv Month	ery Day Year
rds, P	been signed be should be deta	Ď	Part II. Other significant conditions of SENILE	ontributing to death but not resulting to DEMENTIA	ng in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
		Completed						24a. Was an autopsy performe	24b. Were autoprior to codeath?	opsy findings available impletion of cause of
of Vita	certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	05 1	h (Check only one,		
P of	r this aral dii	To I	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28	VOutpatien Bb. Time of	1 3 DOA	4 Le Nursing Ho	ome 5 Resident	ce 6 Other (Speci	(y)
Vision	ath. r: Afte	atior	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day Year)	Injury	28c. Injur Wor M 1 🗆	k? Yes 2 □No		,	
Division of	within 24 hours efter death. To the Funarel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
Hospi	Funar Funar tely fill	Medical	29a. Certifier 1 Cartifying Ph	ysician: To the best of my knowle niner: On the basis of examination	adge, death	occurred at the tir	ne, date and place, pinion, death occur	and due to the cau	ise(s) and manner as s e and place, and due t	stated. o the cause(s)
o the	within 2	Mec		and manner stated.	7	29c. Licens	e number	290	d. Date signed (Month,	Day, Year)
	4°		> Paula	ure Kill	mu	1 Di	3543	6 P	SCEMBER	08,2006
			30. Name and address of person who	completed cause of death (Item 2:	3a) (t. o.	Print) HONTE	DSE RUAL	, ROCK	VILLE MI	520852
	Sta Registr	ite	31. Date filed (Month, Day, Year)	32 Registrar's Signatur	Anan	PLS.				

			for State Registrar	\$	State of	f Maryla	nd / Depa	artmen rtificate	t of H e of L	ealth a D <i>eath</i>	and Me		giene	-	6	41335
	Physic	ion	1. Decedent's Name (First, Mic									2. Date of Dea			'ear	3. Time of Death
	/Medi		Ro			largare	et 	Ham:	ilto	n ———	I	Decembe		8, 20	-	10:50 A ^M
4	Examir	ner	4a. Facility Name (If not institut	. 0						Location of			40	. County of		
			Allegany Cou					If Under		rland If Under					egar	-
	Funeral Director		5. Social Security Number 212–18–1920	6. Sex 1 ☐ M	1 2(X] F	7. Age (in yr. 86	s. last birthday) Yrs.	Months	Days	Hours	Min.	B. Date of Birti (Month, Day	y, Year)			lace (State or Foreign try)
			Usual Residence of Decedent								[1	0/15/1	920	<u> </u>	Mary	land
	ylang		10a. State 10b. Cour	ity		10c. (City, Town or Lo	cation							10	0d. Inside City Limits
	Mar B-f st	to	MD A	legan	У			Cumbe	erlan	ıd						1 X Yes 2 ☐ No
	in the	lrec	10e. Street and Number					10f. Zip	Code				10g. Cit	tizen of Wh	al Coun	try?
	th wil	alD	1 Baltin	nore S	treet				21	502				Ţ	JSA	
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f show Ta Madical Examirer must be nutlined at	Funeral Director	11. Marital Status	12.	Was Dece Armed For	dent Ever in	U.S. 13.	Was Deced	ent of His	spanic Ori	gin? (Spec	ify Yes or No- ican, etc.)		14. Race -	America While, 6	
36	or It	by Fu	1 Never Married 2 M		1 ☐ Yes If Yes, Giv	2 XNo	-	1 ☐ Yes 2		Specify:	,	,		Specify:		
21215-0036	hour turel	d be	3 X Widowed 4 □ Divorc		Year or Da	ites:							151			/hite
5	in 72 "na	Completed	(Specify only high		ompleted)		16a. Deced	kind of wor DO NOT us	k done di	urina mosi	t of working	7	16b. K	and of Busin	ness/ind	lustry
212	I with jene.	mo	Elementary/Secondary (0-12)	College (1	-4or 5+)			esso					Publ:	ic S	Schools
b	filec I Hyg othe	BeC	17. Father's Name (First, Middle	e, Last)							or's Name (First, Middle,	Maiden			0.1.0020
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other then "naturel", or Items 23a or 28a-f show or other treumatic avent, If a Madical Examiner must be nutified at	To B	Roy		Burt		Whitson	1			Cryst	al	M	ae	Gris	wold
<u>la</u>	2 sh and is m	0.3	19a. Informant's Name/Relatio									Route Numbe				Code)
	l and lealth im 27 her tr		Roy Hamilton	/ son		206				ale D		Green				27455
Baltimore,	Pages nent of the ont: If Ite		1 🕅 Burial 2 □ Crematio		oval from S	State	Place of Dispo cemetery, cren	natory or ot	her place		Da			ocation - Cit		
표	it. P.		' 4 ☐ Donation 5 ☐ Other 21. Signature of Fureral Service			Su	nset Me							umber.		
Ba	permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 is any injury or other treu		Kalus	e (1)	a	lan	1	104 De	cati	ır St	reet,	Cumbe	rla			Home, P.A.
			23a. Part1. Enter the disease, shock, or heart failure. L	or complicat st only one	tions that ca	aused the dea	ath. Do not ent	er the mode	of dying	, such as	cardiac or	respiratory arr	est,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_ a.	AM	YOTH	ROPI	e L	AT	ERA	-L 4	SCLE	RO	Sic		Donset and Death
	/Medical Examiner		resulting in death)		Due to (or as a conse	equence of):									
		<u></u>	Sequentially list conditions,	b	Due to (or as a conse	equence of):									
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	000 (0 (0	31 43 4 CONSC	iquence on.									
•	exect n and al-tra	Exal	that initiated events resulting in death) Last	c	Due to (d	or as a conse	quence of):									
8760,	cate be executed physician and the burial-transit	dical													i	
9	ificat g phy as the	0		d												
Вох	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c.		ome of pregr								23d. Date o	f deliver	У
	deatl e atte	lcla	in the past 12 months?		4☐Pregna	rth 2□Fet ant at time of		Ectopic pre Other (spe						Month	Į.	Day Year
P.0	that the de led by the a detached f	hys	9 Unknown		9□ Unkno	wn										
	res tha igned I be det	by F	Part II. Other significant condi	tions contrib	outing to de	ath but not re	sulting in the ur	derlying ca	use giver	n in Part I.		23e. Did tol	bacco u	ise contribu	te to the	a cause of death?
ord	w requir been si should	ted										1 🗆 Ye	es 2	12No 3] Proba	bly 4 □Unknown
Records,	e law r has be	Completed										24a. Was a autops		24b. Wer	e autop	sy findings available pletion of cause of
R		Con										perforr	med? 2 ₩No	deat	th? Yes 2	
Vital	vician: Th certificate rector, pag	Be	25. Was case referred to medic examiner?		-11-1						of Death (Check only on	e)			
of	hye his	6	1 Yes 2 No	Hos	1 🗀 In		ER/Outpatien			4 20 1901		5 ☐ Reside			Specify)	
	ding P	lon	27. Manner of Death 1 Statural 5 □ Pend	ling	28a. Date o (Month	n Day Year)	28b. Time of Injury		c. Injury a			d. Describe ho	ow injur	y occurred		
isi	death death stor: / the	icat	3 ☐ Suicide 6 ☐ Coul	tigation d not be	390 Place	of Injune . At I	nome, farm, stre	M (astern		es 2 N		f Lagation (C)		ed Alexander or a		On the Market
Division	lor A after Direct	Certification;	4 Homicide deter	mined 4	buildin	g, etc. (Spec	ify)	el, ractory,	Office		201	City or Towr	n, State)	or Hurai	Route Number,
_	spital		29a. Certifier 1 Certify	ing Physici	an: To the I	pest of my kn	owledge, death	occurred a	t the time	date and	i niace, and	d due to the ca	zusa/s)	and manne	er ac eta	tad
	To the Hospital or Attending P within 24 hours attendant To the Funerel Director: After to completely filled in by the funera	edical	(Check only 2 Medical one)	ıl Examiner:	On the ba	sis of examin	ation and/or inv	estigation,	in my opi	nion, deat	h occurred	at the time, di	ate and	place, and	due to 1	he cause(s)
	To the within To the comp	Ž	29b. Signature and title of certif	ier	2	,	0	29c.	License	number		2	9d. Dat	e signed (N		ay, Year)
•	2		Udgustier	no (1. 1	ewis	4 1/2	1	2-	148	65	1	120	e. 10	1714	2006
	71 11		30. Name and address of person							- 4					1	7
	nds		Robust				M.D.,	500	Memo	rial	Aven	ue, Cun	nber	land,	MD	21502
	Sta Registr		31. Date filed (Month, Day, Yea	H. A	all!											

			1 = For State Registrar	State of	of Marylan		artment of H			ental Hygi	ene	- 11000
			Registrar 1. Decedent's Name (First, Midd	lo (ast)	· · · · · · · · · · · · · · · · · · ·	Ce	rtificate of	Death			g. No. 4 U U	0 4 1 3 3 6
я	Physic			ite Holli	iday				7	2. Date of Death Month	Day Yea	
+	/Medi Examir		4a. Facility Name (If not institution		<u> </u>		4b. City, Town, c	or Location	of Death	75.CEM	4c. County of De	
			Washington Co	untv Hospi	ital		Hagerst				Washing	ton
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day,	. 9. B	irthplace (State or Foreign
4	Director		225-40-1178	1□M 2□F		79 Yrs.	mornio Bayo	Incurs				rginia
	land		Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Mary -f she fied a	to	PA Frank	lin	Way	nesbor	•					1 ⊠Yes 2 □ No
	n the	Director	10e. Street and Number		, nay	1103001	10f. Zip Code			10	g. Citizen of What 0	Country?
	th wit	a D	112 West Main	Street			17268				USA	
	ems er mi	ne	11. Marital Status		edent Ever in U	.S. 13.	Was Decedent of H	Hispanic Or	igin? (Spec		14. Race - An Black, Wh	
36	s afte ; or it amin	Ž.	1 Never Married 2 Mar	If Yes, Gi	2⊠ No ve		1 ☐ Yes 2 ☑ No				Specify: W	•
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Completed by Funeral	3 Widowed 4 □ Divorced	Year or □	ates:	16a Dece	dent's Usual Occup	nation				
15	in 72 n "na nedic	plet	(Specify only highe	st grade completed)	4.4=5.3	(Give	kind of work done DO NOT use retired	during mos d)	st of working	g	6b. Kind of Busines	s/industry
212	d with giene gr tha the	E	Elementary/Secondary (0-12)	College (1-401 5+)	Seams	stress			İ	Interior	Design
פ	al Hy I othe went,	Bec	17. Father's Name (First, Middle	Last)				18. Mothe	er's Name (aiden Surname)	
yla	ould by Ment arkec	은	Lynwood		Hay	maker		Arie				Deeds
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	107	19a. Informant's Name/Relations	, , , ,							City or Town, State,	
	s 1 and 2 of Health a item 27 is		Patricia Summe	rs (Daught		5 Sou	th Frank	<u>lin S</u>	t. Wa		o, PA 172	
Jor	ages nt of :: If it		1 Burial 2 ☐ Cremation		State	-	sition (Name of matory or other place	· ;		~	0c. Location - City o	
Baltimore,	artme ortani Injury		4 Donation 5 Dother (5		She	22	Name and Addre	ess of Facili	tv			, Virginia
ñ	Dep Imp	d	Dutte	sk		Os	borne Fu . Willia	neral	Home	P.A. 42	25 South	Conococheague
	# #		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that of	caused the deatl	h. Do not ent	er the mode of dyir	ng, such as	cardiac or	respiratory arres	st,	Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition		HUPOXI	A						Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):	esson i					
B	LAdillillei	<u>.</u>	Sequentially list conditions,	b	4410-	15N	100					
	ted nsit	Examiner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury	30010	(Ur de a consequ	1005	AVIA					
,	execunand and all-tra	Exar	that initiated events resulting in death) Last	c	(or as a consequ	uence of):	01010					
8760,	ficate be executed g physician and is the burial-transit	dical		d	FAN	XYC	PROPERIO	4				
Θ	rtifica ng ph	/ledi	IF FFMALE.									
Vital Records, P.O. Box	The law requires that the death certific thas been signed by the attending prage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out	tcome pf pregna pirth 2 Feta	ancy Ideath 3□	Ectopic pregnancy	V			23d. Date of de	
C.	ne deg the at hed fo	sici	1 Yes 2 No	4□Pregr 9□Unkn	nant at time of d own	eath 5□	Other (specify)	, 			Month	Day Year
<u>.</u>	w requires that the dibeen signed by the should be detached	Phy	Part II. Other significant conditi	ons contributing to de	eath but not resu	ulting in the ur	nderlying cause give	en in Part I		23e Did toba	cco use contribute t	to the cause of death?
ds,	signe d be	d by				ago a,	isonying outso give	on mir cart.				Probably 4 Unknown
S	w req been shoul	Completed								24a. Was an		
Re	The lay	щ								autopsy performe	prior to	utopsy findings available completion of cause of
ta		BeC	25. Was case referred to medica]				26 Place	of Death (1□ Yes 2. Check only one)	No 1 ☐ Ye	s 2 No
>	di iši 💆	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Othe	0.51			ce 6 □Other (Spe	ecify)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injur Worl				injury occurred	
Sio	tendi eath. tor: A the fu	catic	2 Accident investi	gation	= ==		M 1 🗆	Yes 2 □ I	No			
Division or	or At after d Direc in by	Certification:	4 Homicide determ	ained 28e. Place	of injury - At ho ng, etc. (Specif)	ome, farm, stro //	eet, factory, office		28	 Location (Stre City or Town, 	et and Number or F State)	lural Route Number,
	e Hospital 24 hours a e Funeral [letely filled		29a. Certifier 1 Certifyin	ng Physician: To the	hest of my kno	wledge, death	occurred at the tir	me date an	nd place, an	d due to the cau	Iso(s) and manner o	o otated
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical one)	Examiner: On the b	asis of examina ner stated.	tion and/or in	vestigation, in my o	pinion, dea	ath occurred	at the time, dat	e and place, and du	e to the cause(s)
	To the within 2 To the comple	Ě	29b. Signature and title of certifie		0 11	\cap	29c. License	e number	.00	290	I. Date signed (Mon	th, Day, Year)
) em	ufair	er m		1000)6°S	>57	6	12/09/	06.
-	ا سر ، ا		30. Name and address of person	\mathcal{O}			· ·				1	
	4-5 Sta	to	Mercy Kurapaty 31. Date filed (Month, Day, Year)		51 E. Ar egistrar's Signa		n St., Ha	gerst	own,	MD 21	740	
	Sta Registr	-	DEC 1		d		antes					
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DHMH 17 Rev 1/2001

State Registrar MELANIA BEMBEA, MD

31. Date filed (Month, Day, Year)

DEC 1 3 2006

WH-1

STREET, BALTIMORE, MD

600 N WOLFE

32. Registrar's Signature

		•	For State Registrar	State of M	arylan		artment rtificate			and M		Reg. No.	006	9 79	338
	Physicia	an	1. Decedent's Name (First, Middle, Las								2. Date of De Month DECEMB		a o Xear		of Death
	/Medic		MARY E		SINS						DECEMB				Ам
	Examin	er	4a. Facility Name (If not institution, give				4b. City,		Location o	of Death			unty of Deat		
E			GENESIS WALDORF CI		e (In vrs.	last birthday)	If Under		If Under	24 Hrs.	8. Date of Bi				or Foreian
	Funeral Director			□M 2X)F	86	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di FEB • 2	2, Year) 2, 192	20 NOR	hplace (State untry) TH CAR	OLINA
	-		Usual Residence of Decedent				I								
	ehow		10a. State 10b. County		10c. Cit	y, Town or La								10d. Inside	City Limits s 2√∏ No
	Ba-f e	Cto	MARYLAND CHARL	ES		WALD							7	L	- X
	death with the Maryland ms 23s or 28s-f ehow	Funeral Directo	10e. Street and Number	01			10f. Zip		0.2				of What Co	•	
	s 23s	a	4140 OLD WASHINGTO	12. Was Decedent	Suprin II	S 12	Mas Dood	206		ain? (Sne	oify Vac or N		Race - Ame		
_	item item	Ş	Marital Status Never Married 2 Married	Armed Forces?	No.	i			n, Mexican	, Puerto	cify Yes or No Rican, etc.)		Black, White		
2	hours after turel', or ite	Ď	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	No D	Specify:			Sp	ecity:	WHITE	1
215-0036	n 72 hours after death with the Maryla "naturet", or ttems 23s or 28s-f ehov adical Examitter, wat be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation		16a. Dece	dent's Usua	Decupa	ition	t of worki	na	16b. Kind	of Business/	Industry	
7	within 72 ene. then "na	np e	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wor DO NOT us)	o workin				_	
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yiand	be fill	Be	17. Father's Name (First, Middle, Last)								(First, Middle E POWE		mame)		
2	d Men d Men narke	ဥ	JOHN CALLAHAN 19a. Informant's Name/Relationship (7)	Tuno Print)		10h Mailie	ag Addross	(Street a			I Route Numb		own State	7in Code)	
2	s 1 end 2 should Health and Mer Item 27 le marke other treumatic		GRADY HIGGINS, II				-				ALDORF			<i>,p</i> 0000,	
o,	is 1 end of Health Item 27 other to		20a. Method of Disposition	1 5011	20b. F	Place of Disposemetery, crer					ate		tion - City or	Town, State	
2	ë = 5		1 ☐ Burial 2X☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			emerery, crer TT CRE				12-14	-2006	WALDO	ORF. M	D. 206	04
Baitimor	nit. Pa vartmen ortant: Injury		21. Signature of Funeral Service Licen								TT FUN				
ă	permit. Departr Importa eny Inju		Mark M. Br	maun							WALDOR		_		
Ī	Physician		23a. Part1. Enter the disease, or compshock, or heart failure. List only immediate Cause (Final	plications that caused one cause on each li	ne.	h. Do not ent								Approxim Interval B Onset and FEW WK	etween d Death
	/Medical		disease or condition resulting in death)	aDue to (or as											
	Examiner		Sequentially list conditions	b											
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):									
	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	2 20022	wanco of):									
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280	physicate the	dical	•	d											
BOX (death certifical e attending phi id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fete	ol death 3	Ectopic pre					230	I. Date of del Month	ivery Day	Year
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ras, r	w requires that the been signed by th should be detache	Ď	Part II. Other significant conditions of DEMENTIA	ontributing to death b	out not res	ulting in the u	nderlying ca	use give	in Part I.	•				the cause of obably 4X	
Hecord	\$ 0°	Completed	FAILURE TO TH	RIVE							24a. Was		24b. Were au	topsy finding	s available
	The ate has page	E									perf	ormed?	death?		
VItal	siclan: The la certificate ha irector, page 2	Be C	25. Was case referred to medical examiner?							of Death	(Check only	one)			
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	ding Ph h. After thi funeral	-io	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry y Ye <i>ar)</i>	28b. Time o Injury	м 2	Bc. Injury Work	at ? /es 2 🔲 l	1	28d. Describe	now injury o	ccurred		
<u> </u>	Attending ir death. ector: After by the funer	Cat	2 Accident investigation 3 Suicide 6 Could not be		iury - At h	ome farm sti					28f. Location	(Street and N	lumber or Ru	ıral Route Nu	ımber.
DIVISION	of or Attence after death of Director:	Certification:	4 Homicide determined	building, et	c. (Specif	(y)	ooi, lactory	, omos				wn, State)			
	Hospite 24 hours Funeral stely fille	edical C	29a. Certifier Check only one) Check only	ysician: To the best niner: On the basis o and manner st	of my kno of examina	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, a	and due to the	cause(s) an	d manner as ace, and due	stated. to the cause	9(S)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	^ .			29c	. License	number			29d. Date s	igned (Monta	h, Day, Year)	
	- 7 - 0			-gay	Ad	ENDIN		D444	36			DECEMI	BER 8,	2006	
(30. Name and address of person who		death (Iter	п 23а) (Туре,	Print)								
۱	135		ASHVIN J. PATEL,				N CT.	#10	2, WA	ALDOF	RF, MD	20602			
	Sta Registr		ASHVIN J. PATEL, M.D., 102 PAUL MELLON CT. #102, WALDORF, MD 20602 31. Date filed (Month, Day, Year) 32. Paistrar's Signature												

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dorothy J. Hopkins 11/28/06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Corsica Hill Nursing Home Centreville Queen Annes If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month Day, Year) 4/18/67 Birthplace (State or Foreign
 MD **Funeral** Months 1 ☐ M 2**X**) F 217-08-2759 39 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County in than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Funeral Director MD 1 ☐ Yes 2 ☐ No Kent Rockhall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5167 Harris Rd 21661 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: XNever Married 2 ☐ Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Completed by Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Crabhouse 12 Prep Cook permit. Pages 1 and 2 should be filled Department of Health and Mental Hyg Importent: If Item 27 is marked other any injury or other treumatic event, I 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Rudolph Hopkins Sr Florence Laster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Wilson (aunt) 21471 Grays Inn Landing Rockhall MD 21661 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Aaron's Church Cem 12/9/06 Rockhall, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith FH-Worton, MD 2haw 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Zerdionyepathy Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Examiner 1dul 12213 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, physician IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 DEctopic pregnancy ρ Month Day Year 5 Other (specify) 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, eq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? (es 28 No page. 1 Yes Vital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To of 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Division Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 2 Accident the 3 Suicide 6 Could not be determined in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and man er stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Na e d addr s of person who completed cause of death (fem 23a) (Type, Print) Dus demans 31. Date filed (Month, Day, Year) 32. Registy 's Signature State Registrar 2006

			For State Registrar	State of Ma	arylan		artment of I				giene Reg. No.	006	41340
			1. Decedent's Name (First, Middle, La	st)						2. Date of De Month	eath Day	Year	3. Time of Death
	Physicia /Medic		Audrey P. F	latton						12	4	06	0205AM
Y	Examin		4a. Facility Name (If not institution, giv				4b. City, Town,	or Location	n of Death		4c. C	ounty of Deat	h
			Coastal Hospice	At The L	ake		Salis	buch			4	DICOM	، ندم
	Funeral		5. Social Security Number 1 6. S	ex 7. Age		last birthday)	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Bir (Month, Da 9/25/1	rth X. <i>Year)</i>	9. Birtl	hplace (State or Foreign untry)
	Director		005-30-7912		76	Yrs.		1		9/25/1	930	Mair	ne
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	Aaryli r sho	5	Maryland Wicomic	_	Ga1	lisbury	7						1 ☐ Yes 2 X No
	28a-	Directo	Maryland Wicomico	,	ממו	LISDUL	10f. Zip Code				10g. Citize	en of What Co	untry?
	with a or	<u>=</u>					21804				USA		
	ne 23	era	4745 Cardinal Dr.	12. Was Decedent I	Ever in U.	.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic (Origin? (Sp	ecify Yes or No		4. Race - Ame	
	r iten	Funerai	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 🕱 N	No					Rican, etc.)	ľ	Black, White	
93	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 □ Yes 2 🖾 No	Speci	fy:		5	Specify: Whi	te
21215-0036	4 within 72 hours after death with the Maryland Jiene. r then "netural", or iteme 23a or 28a-f show the Medical Examiner must be neillfied at	Completed by	15. Decedent's E (Specify only highest gra	ducation		16a. Dece	dent's Usual Occu kind of work done	pation	ost of work	una	16b. Kind	d of Business/	Industry
21	등 . c 릨	pie	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT use retire	∍d)					
7	ified within Hygiene. other ther	50	12	2		Admin	istrator					ont Cor	mpany
Maryland	be filed ital Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)						e (First, Middle		iu <i>mame)</i>	
Va		2	Fred Potter							Bradle			
an	and and ls my		19a. Informant's Name/Relationship (ng Address (Stree						
	5 5 5 5		Phillip Hotton/Hu	sband	00h 5		Cardinal	Dr.		oate Isbury,			
ore	000		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	- · · c	emetery, crei	nsition (Name of matory or other plants and monage)			Date	200. Loc	ation - City or	rown, State
Ë	Pages ment of ant: If its		4 ☐Donation 5 ☐ Other (Special	y)	Pa	rk	Memoria		12/1	1/06	Sali	sbury,	Maryland
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Life	see CF	<i>r</i> 0	H	2. Name and Addr Iolloway	Funer	cal H	ome P.A			
	₹0 # 9 q		Kett 1C N	riney It.	P	5	01 Snow	Hill	Rd.	Salisbu	ry,Ma	ryland	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each lir	the deat	h. Do not en	ter the mode of dy	ing, such a	as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Oue to (or as	a conseq	uence of):							
	Examiner		Sequentially list conditions,	b									
	pe is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence or):							
	and tran	каш	that initiated events resulting in death) Last	c Due to (or as	a consed	neuce of):							
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87	The law requires thet the death certificate be executed sie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	•	d									
9 x	Jeath certifica attending phi I for use as th	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	incv					20	3d. Date of deli	ivos.
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1☐Live birth	2 Feta	Ideath 3	Ectopic pregnand Other (specify)	Э			25	Month	Day Year
	the de by the a	ysic	1 ☐ Yes 27 No 9 ☐ Unknown	9□ Unknown	titile or d	eatir 5	_ Other (apaciny) _		-				
P.0	thet the		Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	inderlying cause gi	ven in Pa	rt I.	23e. Did 1	tobacco us	e contribute to	the cause of death?
ds,	signed be de	d by								10	Yes 2	No 3□Pr	obably 4 Unknown
Records,	w requir been si should I	Completed								24a. Was	20	24h Were au	topsy findings available
3ec	e law has	g								auto		prior to death?	completion of cause of
a F	sician: The certificete har rector, page									1 ☐ Yes	2 2 No	1 🗆 Yes	2DTNo
Vital	Physician: 1 this certificer ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		50:0		thos		h (Check only		T011 (0	
ot	Phys rthis ral di	-T	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		ER/Outpaties 28b. Time o	nt 3 DOA	4 🗆	Nursing Ho	ome 5 Resi			oiry)
LO C	ding h. Alter funer	E I	→ Natural 5 Pending	(Month, Da	ý Year)	Injury	We	ork?]Yes 2	□No		, ,		
:	or Attending after death. Director; After in by the fune	lica	# Accident Investigation ### Accident Investigation #### Accident Investigation ###################################	OB Bloom of Init	urv - At ho	ome, farm, st	reet, factory, office					Number or Ru	ıral Route Number,
Division	i or A after Dire	Certification:	4 Homicide	building, et	c. (Specif	y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or To	wn, State)		
	spita cours nerai			nysician: To the best	of my kno	wledge, deat	h occurred at the t	time, date	and place,	and due to the	cause(s) a	ind manner as	stated.
	24 h 24 h Fui	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	f examina ated.	tion and/or in	vestigation, in my	opinion, d	eath occur	red at the time,	date and p	place, and due	to the cause(s)
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director; Atter this completely filled in by the funeral director.	Me	29b. Signature and title of certifier	118	Ν.		29c. Licen	se numbe	C		29d. Date	signed (Monti	h, Day, Year)
	- 1 B		1)1/2 (/ N	W		DA	162	10		12	-4-0	6
	100		30. Name and address of person who	completed cause of d	eath (Iten	п 23а) (Туре,	Print)		1	. ,)			
	40		DavidE Coreal	1, MD Con	Steel A	4050ic	POBOX 1	733		sclish	M	2/8	02
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	iture				()		
	Regist		DEC 08	2006	MA	1. 1	book!						

			1 - For State Registrar		of Maryla		artmen rtificat					g. No. U	06	41341
75	Physici	an	1. Decedent's Name (First, Middi	e, Last)						2	2. Date of Death Month	Day	Year	3. Time of Death
	/Medic		ROBERT		ORDAN						December		2006	10:00 P ^M
	Examin		4a. Facility Name (If not institution	-					Location of				inty of Death	
	÷ ·	-1.1	shington Advent	ist Hospi		rs. last birthday)	-	rer S	prin		. Date of Birth	Mon	tgomer	
	Funeral Director		578-50-4895 Usual Residence of Decedent	1⊠M 2□F	70 70	Yrs.	Months		Hours	Min.	(Month, Day,	Year) 1936	Wash	place (State or Foreign ntry) nington, DC
	land ow		10a. State 10b. County		10c.	City, Town or Lo	ocation							10d. Inside City Limits
	Mary	tor	MD PRINCE	E GEORGE'S	5 M	T. RAIN	TER							Yes 2 ☐ No
	7.28e	Funeral Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen	of What Cou	ntry?
	38 o 18	O E	4507 Russell Av	'e .				20	712				USA	
	deat	ner	11. Marital Status		edent Ever in	U.S. 13.	Was Dece			gin? (Speci	fy Yes or No- can, etc.)		Race - Ameri	
٥	or Ite	F	1 Never Married 2 Mar	ned 1 Yes			1 Yes		Specify:	i, Fuelto M	can, etc.)		Black, White,	
5-0036	ours,	d by	3 Widowed 4 Divorced	Year or [Dates:		1 1 1 63	2 X 140	эрвспу.			Spe	Afri	can America
S S	is 1 end 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiane. Item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examinal matches incillies at	Completed	15. Deceder (Specify only highe	it's Education st grade completed)		16a. Dece (Give	dent's Usu	al Occupa ork done d	ation during mos	t of working	, 1	6b. Kind o	f Business/In	ndustry
2	nehin Nen	прi	Elementary/Secondary (0-12)	T .	1-4or 5+)	life.)					
2	led w tygies her ti		12th	(act)			Prin	ter	10 Math	ndo Nome /	Circa Mintella M		ov t	
Maryland	tal H d ot	Be	17. Father's Name (First, Middle,								First, Middle, M	aiden Sun	name)	
3	Mer Mer Marke Marke Marke	Jo	Robert L.		dan, S				Alm			nes		
a a	12 should be filed within ? h and Mental Hygiene. 7 is marked other than "! freumatic event. Its Mas.	. :=	19a. Informant's Name/Relations				•				Route Number,			
	1 end Health em 27 ther tr		Carlton J Jor	аап/ зоц	201	D. Place of Dispo			th Av	re. #			on - City or To	MD 20710
Baltimore,	9 = 5		1 Burial 2 Cremation 4 Donation 5 Other (5	3 □Removal from Specify)		cemetery, cre iverdal	matory or c	ther place	y		/2006 R			
Balti	permit. Pa Departmer Important any Injury once.		21. Signature of Funeral Service	Licensee — Lac	11						Jenkin Landove			
8760,	Physician and /Medical Examiner portion and portion and the portion and the portion and the portion and the portion and the portion and the province of the pr	cai Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a cons) H	<u>e</u>	e50	Thay	gus.			Interval Between Onset and Death
P.O. Box 68	the death certific by the attending p ached for use as	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 ☐ Fe nant at time o	etal death 3	□Ectopic pi □ Other (sp						Date of delive	ery Day Year
	uires that signed t id be det	þ	Part II. Other significant conditi	ons contributing to o	leath but not r	esulting in the u	inderlying o	ause give	en in Part I.			cco use c		he cause of death?
Records,	sician: The law requir certificate has been si irector, page 2 should	Completed									24a. Was an autopsy perform		b. Were auto prior to co death? 1 \(\sum \section \text{Yes}	opsy findings available impletion of cause of
Vita	artific ctor.	Be (25. Was case referred to medica examiner?	1					26. Place	of Death	Check only one			
<u>o</u>	Physician: this certific ral director.	2	1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 D	OA Othe	er: 4 □ Nu	rsing Home	5 🗆 Residen	ce 6 🗆	Other (Specif	fy)
0	ding P	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o	if 2	28c. Injury Work	at c?	28	d. Describe how	injury occ	curred	
<u>0</u>	Attending r death. ector: After by the fune	cati	2 Accident investi	gation			М	1 🗆 ነ	Yes 2 □	No				
DIVISION	or Att	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place	e of Injury - At ling, etc. (Spe	t home, farm, st <i>icify)</i>	reet, factor	y, office		28	 Location (Street) City or Town, 	et and Nu State)	mber or Rura	al Route Number,
2	itel curs af													
	Hosp 4 hos Fune ely fin	ical	(Chack only 2 Medical	ng Physician: To the Examiner: On the b	pasis of exami	nowledge, deat ination and/or in	h occurred vestigation	at the tim	ie, date an pinion, dea	d place, an th occurred	d due to the cau	ise(s) and e and plac	manner as s	stated. o the cause(s)
	To the Hospitel or Attanding Physician: The i within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one)	and mar	nner stated.									
	Viti Con	~	29b. Signature and title of certifie	Call	- 17		29	c. License	number	. ~	29	uate sig	ned (Month,	Day, Year)
	\circ		100	TUSS	76			DL	175	1+	7	12	101	-106
_1	6	1	30. Name and address of cerson	no completed cau	se of death (It	tem 23a) (Type,	Print)		Par	~4	221		0).	(1 1) 1/2
	7		yeney ?	rung	リング	16 17	20		VV	UM	11940	27	MOV	With HOS
	Sta Registr		31. Date filed (Mortiff Day, Year,	ho	Tegistrar's Sig	bock					/			

			1 - For State Registrar	State of Ma	ryland / Depa	artment o			giene Reg. No 006	41342
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	Day Year	3. Time of Death
	/Medic Examir	cal	Bertha Irene 4a. Facility Name (If not institution, give Joseph Richey Hospice	,	1	4b. City, Tow	n, or Location of De	December	5, 2006 4c. County of Death	7:00 Рм
	Funeral Director		Social Security Number 6. Se		(In yrs. last birthday) 94 Yrs.	If Under 1 Ye			(, Year) Cos	oplace (State or Foreign untry) ginia
	faryland	ō	Usual Residence of Decedent 10a. State 10b. County MD Anne Aru	ndel	10c. City, Town or Lo					10d. Inside City Limits 1 Yes 2 No
	with the N Sa or 28a-	I Director	10e. Street and Number 7101 Madden Court, Ut			10f. Zip Coo			10g. Citizen of Whal Cou	unlry?
920	72 hours after death with the Maryland natural', or iteme 23a or 28e-f ehow dical Exactions from the profified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nowled 4 Divorced	12. Was Decedeni E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0		of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		
Baltimore, Maryland 21215-0036	C * 3	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Oc kind of work do DO NOT use re	one during most of v stired)	vorking	16b. Kind of Business/li	ndustry
yland;	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) George Chambers					lame (First, Middle, Bailey	Maiden Sumame)	
, Mar	s 1 and 2 should f Heelth and Mer item 27 is marks other traumatic		19a. Informant's Name/Relationship (T) Susie Henderson-Daugh	•	7101	Madden (t	ourt, Unit H	F, Ft. Meade		
timore	permit. Pages 1 Department of H Important: If Ite eny injury or oth		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		Riverdale P	natory or other ark Creme	atory 12-		20c. Location - City or T Rivercale, MD	
Bal	Depar Impo		21. Signature of Funeral Service Licens	Juin		504 28th	St., N.E.,	WLC: 20018	oc. Funeral Ho	
	Physician /Medical Examiner	Examiner	23a. Part Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a	consequence of):	dem	antia	ac or respiratory an	,	Approximate Interval Between Onset and Death
x 68760,	law requires that the death certificate be executed as been signed by the ettending physicien and as been signed by the ettending physicien and as should be detached for use as the burial-transit	Physician/Medical Exar	resulting in death) Last	1	consequence of):					
.O. Box	at the death c by the ettend tached for us	hysician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	Ectopic pregna Other <i>(specif</i> y			23d. Date of deliv Month	very Day Year
ords, P.	w requires that been signed I should be det	þ	Part II. Other significant conditions col	ntributing to death but	I not resulling in the u	nderlying cause	given in Part I.		bacco use conIribute Io	
of Vital Records,	The ete h page	Completed							med? 21 No 1 ☐ Yes	opsy findings available ompletion of cause of
ion of Vit	Physic this ce	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Watural 5 Pending 2 Accident investigation	lospital: 1 Inpatien 28a. Date of Injury (Month, Day		28c. I	Other		ence 6 🖾 Other (Speci ow injury occurred	Maspice
Division	itel or Attendering setter deatl	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, offi	се	28f. Location (S City or Town	treet and Number or Rur n, State)	al Route Number,
	To the Hospitel or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	Medical	one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	examination and/or in	vestigation, in n	ry opinion, death oc	curred at the time, d	ause(s) and manner as a ate and place, and due t	o the cause(s)
^	or with	-	29b. Signature and title of certifier	Jal		21	ense number 30/2		9d. Date signed (Month,	Day, Year)
NZ	(3)		30. Name and address of person who of	Impleted cause of dea	il Madel	Print)	The It	The M	1 2/2/	<i>'P</i>
	Sta Registr		pro 0.8 2006	A De l'agracial	1. South	Ī				

Physician /Medical Examiner Lagora B. Johnson Mor Dec Grand Security Name (If not institution, give street and number) Heartland Health Care Center Hyattsvile 5. Social Security Number 6. Sex 77 – 42 – 9171 Director Director Director 10a. State 10b. County 10c. City, Town or Location	ember Per of Birth hith, Day, Ye 14/193	35 Was	_	
Heartland Health Care Center Hyattsvile	Pe of Birth hith, Day, Ye 14/193	Prince Ge par) 9.8im CC Was	orge's thplace (State or Foreign buntry) hington, D.C. 10d. fnside City Limits	
Funeral Director 5. Social Security Number 6. Sex 1 Months Days Hours Min. 8. Date (Mo. 8/) Usuaf Residence of Decedent 5. Social Security Number 6. Sex 1 Months Days Hours Min. 8. Date (Mo. 8/)	a of Birth hith, Day, Ye L4/193	9. Bin Co 35 Was	thplace (State or Foreign buntry) hington, D.C. 10d. fnside City Limits	
D	Un s or No-	Citizen of What Co		
10e. Street and Number 10f. Zip Code 20783	Un s or No-	Citizen of What Co	122.00 200.00	
	or No-	10g. Citizen of What Country? United States		
MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10f	etc.)	14. Race - Ame Black, White Specify: B1	erican Indian, - te, etc.	
Secondary (0-12) Specify: S		rivate	/Industry	
N p b 1 1 1 Deautician 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)				
Granville J. Gaither, Jr. Elizabeth To				
The state of the s				
20a. Method of Disposition 1		Location - City or		
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort L: 3401 Bladensburg Road				
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respire shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzeimers Dementia	atory arrest,		Approximate Interval Between Onset and Death	
Examiner Sequentially list conditions, frame, leading to immediate b. Due to (or as a consequence of):				
cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events causing in death) last				
ificate be experience of the private				
in the past 12 months? To be past 12 months? 1 1 1 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of de Month	livery Day Year	
	Did tobaco		o the cause of death?	
Peripheral Vascular Disease	a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of	
1 C S S Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 No Nursing Home 5 S		2 CON (2	7.	
25. Was case referred to medical examiner? 1		njury occurred	city)	
28d. De composition of Death 1	28f. Location (Street and Number or R City or Town, State)		ural Route Number,	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 11X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due and manner stated.	time, date	and place, and due	e to the cause(s)	
5 Cen NO D 0058290		Date signed (Mont	th, Day, Year)	
30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Sureshkumar Mattath, MD 4203 Queenbury Road Hyattsv:	ille.	MD 20781		
State Registrar State Registrar 12	,			

			1 - For State Registrar	State of Ma	aryland		artment o			d Mer		ene2	006	41344
	Physici		1. Decedent's Name (First, Middle, Last) 5AM VEL	. /	ONL	c 5	Jr.			2.	Date of Death Month	Day	Year 2000	3. Time of Death 2240 M
	/Medic Examir		4a. Facility Name (If not institution, give s Anne Arundel M	treet and number)		- 1	4b. City, To		ocation of D nnapolis		15	<i>O G</i> 4c. Cou	unty of Death Anne Al	
	Funeral Director		5. Social Security Number 214-54-7871 6. Sex	7. Ag	e (In yrs. la 57	ast birthday) Yrs.	If Under 1 \ Months D		f Under 24 Hours	Hrs. 8. Vin.	Date of Birth (Month, Day, Feb 14, 1		9. Birth Cou	place (State or Foreign ntry) Naryland
	Maryland a-f show	ctor	10a. State 10b. County MD Anne Ard	undel	10c. City	, Town or Lo	ocation	Α	nnapolis	s				10d. Inside City Limits 1 ☐ Yes 💥 No
	a or 28	i Dire	10e. Street and Number 29 West Washington St.				10f. Zip Co		21403		10g. Citizen of What Country? U.S.A.			*
920	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or itema 23a or 28a-f show umatic event, Ira Madical Exertire results in published at	by Funeral Director	11. Marital Status Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 201 If Yes, Give Year or Dates:			Was Deceden If Yes, specify		anic Origin Mexican, P Specify:	? (Specify uerto Ric	/ Yes or No- an, etc.)		Race - Ameri Black, White ecify: Black	etc.
Baltimore, Maryland 21215-0036	within 72 hou jiene. r than "natura ine Madical E	Completed by	15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5	5+)	16a. Deced (Give life.	dent's Usual C kind of work of DO NOT use i Cem	ione dur etired)	on ing most of inisher	working			Self-employed	
	uld be filed Mental Hyg irked otheric event,	To Be C	17. Father's Name (First, Middle, Last)	muel Jones,	Sr.			18	8. Mother's	Name (F	irst, Middle, M Doro	faiden Sun thy Cre		
Man	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or itema 23a or 28e-f show any injury or other traumatic event, the Macingal Examiner must be notified at ODGe.		19a. Informant's Name/Relationship (Ty) Tanya Parker/daughter	oe, Print)		1	ng Address <i>(S</i> Gator Cou				oute Number, 2	City or To	wn, State, Zij	o Code)
more,			20a. Method of Disposition	emoval from State	Ce	metery, crer	sition (Name natory or othe hurch Cem	r place)		Date 12/14/0		Oc. Location	. Location - City or Town, State Lothian, MD	
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,								MD 206	78		
8760,	Medical physicien and horizing that the burial transit	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any reading to immovate the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												Interval Between Onset and Death
P.O. Box 68	w requires that the death certifics been signed by the attending pl should be detached for use as t	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pregr Other (speci						Date of deliv Month	ery Day Year
	quires that n signed by uld be deta	þ	Part II. Other significant conditions con	RENAL	17	PILVA		e given	in Part I.			acco use c		he cause of death?
al Reco	rsician: The law re- s certificate has bee lirector, page 2 sho	Completed	DinBete	5 7	ype	2				-	24a. Was ar autopsy perform 1 Yes 2	,	prior to co death?	opsy findings available mpletion of cause of 2□ No
Division of Vital Records,	ding Phy I. After this funeral o	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da	ry	ER/Outpatien 28b. Time of Injury		Other: Injury at Work?	4 🗌 Nursin	ng Home	heck only one 5 ☐ Resider Describe hor	nce 6 🗆 (5y)
DIVIS	ital or Attendris after deathrai Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et			eet, factory, o	fice		28f.	Location (Str. City or Town,	reet and Number or Rural Route Number, n, State)		
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in y	edical	29a. Certifier 1 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one)	ician: To the best ner: On the basis o and manner sta	f examinati	vledge, death ion and/or in	occurred at t vestigation, in	he time, my opin	date and pi ion, death o	lace, and occurred a	due to the ca at the time, da	use(s) and te and plac	manner as s ce, and due t	tated. o the cause(s)
	To the Ho within 24 To the Fu completel	W	29b. Signature and title of certifier	Steinbe	01	Me	29c. L	cense n	umber 5/	58	29	29d. Date signed (Month, Day, Year)		
	5		30. Name and address of person who co	mpleted cause of d	leath (Item	23a) (Type,	Print) (s/		51		DY 31	in e	120	764
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	s Signat	ure #	Coase			7			·	

Records, P.O. Box 68760 Division or Vital To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

State

29b. Signature and title of certifier ddress of person w Cooke, M.D 29c. License number D04602

2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) December 8, 2006

mbleted cause of death (Item 23a) (Type, Print). 10400 Connecticut Avenue, Kensington, MD 20895

31. Date filed (Month, Day, Year) 11

29a. Certifier

Medical



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) 6

State of Maryland / Department of Health and Mental Hygiene (1) 6

Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 10, 2006 **Physician** 4:30 A M June A. Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Middletown 8203 James Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept | 6, 1939 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Tennessee 410-64-7265 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Iteme 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Maryland Middletown Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21769 8203 James Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) -(unk.) Mary Buckner Adrian Allman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . 8203 James Street Middletown, MD 21769 David W. Jones/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
Important: If Ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 12/12/06 Beltsville, MD 21. Signature of Funeral/Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01251 Beverly L. Heckrotte, P.A. C.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition a Ischemic Colitis with Failure to Thrive weeks **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Supraventricular Tachycardia years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed vears Dementia attending physicien and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical vears Hypertension IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? by B-12 deficiency, dysphagia, cerebrovascular accident, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed gastroesopheageal reflux 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 XNo or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐XNo 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Xiatural 1 □ Yes 2 □ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - Af home, farm, street, factory, office building, efc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 11, 2006 D54749 302 30. Name and address of person who completed cause of death (ftep 23a) (Type, Print) Allen Reilly, M.D. 801 Toll House Ave. D-1 Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State Registrar

			Please	Type or Print				•	•	
			For State	State of Mai			lealth and Me	ntal Hygier	Bans	1.131.7
			Registrar		Cer	tificate of		Reg. I	10:- 0 0 0	91041
	Physici	an	Decedent's Name (First, Middle, Last				2	P. Date of Death Month	Day Yeer	3. Time of Death
	/Medic		Dorothy	Mae	John			Dec. 4	2006	8:33AM
7	Examin	er	4a. Facility Name (If not institution, give			page.	r Location of Death		4c. County of Death	
			205-Wright		enue	Eas			Talbot	
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, Yea	9. Birth	nplace (State or Foreign untry)
	Director		016-36-1108		27 113			July 21,1	952 De	laware
1	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Aaryl F sho	5	MD Talbo	.4	Fa	ston				1 PYes 2 No
Y	28a-	ect	10e. Street and Number		Lu.	10f. Zip Code		10g.	Citizen of What Co	untry?
X	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show hs Medical Examinar must be indiffical at	Funeral Director	1 4 / 1 1	I can 1	1000118	21	601		USA	,
7	eath	era	205-Wrigh 11. Marital Status	12. Was Decedent Ev	verin U.S. 13.V		60/	ifv Yes or No-	14. Race - Amer	nican Indian,
0	fter d	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		_	lispanic Origin? (Spec an, Mexican, Puerto R	can, etc.)	Black, White	, etc.
936	urs aff	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	,	1☐ Yes 2☑ No	Specify:		Specify:	K
5-0036	72 hours natural' lical Ex	Completed	15. Decedent's Ed	ducation	16a. Deced	dent's Usual Occup	pation	16b	Kind of Business/l	
218	I within 72 ho iene. r than "natur the Medical	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+	.)		during most of working d)			
2121	D (D)	No.	, , , , , , , , , , , , , , , , , , , ,	5+	EleN	lentary S	School Prin 18. Mother's Name	cipa l'o	unty Boa	rdof Ed.
pu	be filed ntal Hygie od other event, t	Be (17. Father's Name (First, Middle, Last)			_ /			4	
<u>a</u>	uld b Ment urked utic e	10	Dewitt Her	bert Mar	shall v	Johns	Doroth	4 Mae	Brumi	ne//
Maryland	2 should be f and Mental h Is marked of raumatic eva	ľ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rural	oute Number, Cit	y or Town, State, Z	ip Code)
	5 # 72 T		Rose Pin	der	720	t-Sleep:	Soft Circl		ubia Mi	0,21043
Baltimore,	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	□Romoval from State	20b. Place of Dispo cemetery, cren	sition (Name bf natory or other plac	ce) Da	te 20c.	Location - City or 7	fown, State
Ĕ	Pages nent of I ant: If its		'4 □ Donation 5 □ Other (Specif		Richard	SMEM. PO	2rk 12/9	106 E	aston,	MD.
att	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Licer	nsee	22	. Name and Addre	ss of Facility		1	Wednesday
Ф	<u>8</u> 8 <u>E</u> 8		Janelle	C. Se	vry 5	LID WIDS	ineral H	Sto CAN	bridge	MD121613
	100		23a. Part Enter the disease, or com shoot, or heart failure. List only	plications that caused to	the death Do not ent-	er the mode of dyir	ng, such as rdiac or	respiratory arrest,	01	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	P	(mon over	FI bus	16		1	Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):	10000				3 72005
	Examiner		Conventially list appointings	5-15	stanic (Upus 5	ontherrata	513		57ec
		ner	Sequentially list conditions, if any, leading to intrinsulate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	1				
	cutec nd ransi	Examiner	that initiated events	c						
60,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
<u></u>	ate be nysici he bu	icai		⊾ d						
.89	eath certificate I attending physi I for use as the t	Medic	IF FEMALE:							
Box	ith ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1□Live birth 2		Ectopic pregnancy	y		23d. Date of deli	very Day Year
	e dea he at	Physician/M	1 □ Yes 2 ☑ No	4□Pregnant at ti 9□Unknown	ime of death 5	Other (specify) _			THOUSE IT	Day Foa
P.0	that the de ed by the a detached t	Phy	9 Unknown					One Didashees		the seven of death?
	res tha igned be de	by	Part II. Other significant conditions of	contributing to death but	t not resulting in the til	nderlying cause giv	en in Pant.			the cause of death?
oro	w requir been si should l	ompleted						1 163	2010 0011	
ec	e law has b je 2 st	ηple						24a. Was an autopsy	prior to c	topsy findings available completion of cause of
<u>=</u>	The Tate has page	Con						performed		2 🗆 No
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?			Dia	26. Place of Death	Check only one)		
É	Physi this c ral dire	P	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatien			4 Nursing nom		6 ☐Other (Spec	ify)
- L	Jing P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Wor	rk?	ld. Describe how in	jury occurred	
sio	Attendii death. ctor: A y the fu	cati	2 Accident investigatio 3 Suicide 6 Could not b				Yes 2 □No			
Division of Vital Records,	or At fter c Direction by	Certification:	4 Homicide determined		ry - At home, farm, str (Specify)	eet, factory, office	28	City or Town, St	and Number or Ru ate)	rai Houte Number,
	urs a		20 Carifica A E Cariffica Di	husisias Tarta tara					()	
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director. page 2 should be detached for use as the	edicai		hysician: To the best of miner: On the basis of and manner state	examination and/or in-					
	thin 2 tha mpte	Mec	29b. Signature and title of certifier	and mainer state	90.	29c. Licens	se number	29d.	Date signed (Month	1. Dav. Year)
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			1011xcci	OK .			1018/	12	- 1 - 60	70 G
			30. Name and address of person who RUSS(1) 4) Scho	completed cause of de	am (mem 23a) (Type,	enny A	r Easte	inh	211.21	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	wood A	COSIC	21 171 0	21601	
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			State of Maryland / Department of Health and Measure State and Measure State of Death 1 - For State Registrar Certificate of Death	ental Hygie	2006	41348
·K	Physici	an		2. Date of Death Month	Day, A'ear	3. Time of Death 2: 30 f M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	120	4c. County of Death	04 30 A
	5	\$5	Patricia Johnson Homz For Elderly Pocomoke 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8	O. Data of Birth	Worces	
b	Funeral Director		5. Social Security Number 6. Sex 1 M 2 VF 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	ar) Cour	lace (State or Foreign
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	e Mary a-f sho tified a	ctor	VA Accomack Chincoteague			1 ⊈Yes 2 No
	with than a or 28	Funeral Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cour	itry?
	death ms 23	neral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spectif Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - Americ	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	If Yes, Give 3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 □ No Specify:	rican, etc.)	Black, White,	etc.
15-(iin 72 h n "natu Medica	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	g 16b	. Kind of Business/In	dustry
	filed withi Hygiene. Ither thar	Com	Elementary/Secondary (0-12) College (1-4or 5+)		Selt	
and	ould be fil Mental H arked oth atic even	Be	17. Father's Name (First, Middle, Last)	(First, Middle, Maid	den Surname)	
Maryland	2 should be and Mental is marked c	P.	19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural	Route Number, Ci	ty or Town, State, Zip	Code)
_	ges 1 and 2 t of Health If item 27 or other tra		Barbara Kambarn Daughter Ha4b Ridge Rd. Ch 20a. Method of Disposition (Name at) Da	nincotco	DOUZ VA	<u> </u>
mor	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	3/06 T	- CMPerano	
Baltimore,	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	01001		VA 23336
	20 = a 0	1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest.	1 Church S	
Į	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CELER ROVAS CLAR Accordation	IDEN		Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	7.0		4.0
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	ecutec and I-transi	Examiner	Cause (Disease or injury that initiated events c			
8760,	icate be executed physician and the burial-transit	ical E	d			
Ö	ertificat ling phy e as th	Medi	IF FEMALE:			
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown 1 ☐ Unknown 1 ☐ Unknown 2 ☐ Pregnancy 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delive Month	Pry Day Year
Δ.	res that igned by	by Ph		23e. Did tobacc	co use contribute to the	ne cause of death?
Records,	w require been sig should b				2 SKNo 3 Prob	
Rec	The lay cate has page 2 s	Completed		24a. Was an autopsy performed	prior to condeath?	psy findings available npletion of cause of
Vital	Physician; Th r this certificate ral director, pag	BeC	25. Was case referred to medical examiner?		NO TES	2
o	Phys this al dii	: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	e 5 Residence	e 6 ☐Other (Specifing occurred	/)
sion	Attending I ar death. rector; After by the funer	ation	2 Accident investigation M 1 Yes 2 No			
Division	al or Attend after death. Director: / d in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify)	8f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
	To the Hospital or a within 24 hours after 7 To the Funeral Dire completely filled in E	dical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place are considered in the property of the passes of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, date	and place, and due to	ated. the cause(s)
	To t withi To tl	Ň	29b. Signature and title of certifier The property of the pro	29d.	Date signed (Month,	Day, Year)
1			30. Nam/and address of person who completed cause of death (Item 23a) (Type, Print) 845 57, POCE	omoke	Ctam	2
7	Sta Registr	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		-218	3/
		ar :	DEC U & ZUUG Planting H Some ?			

State of Maryland / Department of Health and Mental Hygiene State
Registrar #1 per DR/wichd/12-11-06/d1 Certificate of Death Amend item 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day М JAVAT James E. Jones 17 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 391136414 HICOMICO REGIONA If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Davs Hours Min 9-2 Director Usual Residence of Deceden 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatil and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Funeral Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12-12-06 Upper-H Cen. of Funeral Service License 21. Signature BOX 33/ Polomike 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -1Po tensoum **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: page 2 should be detached for use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2⊟No 1□ Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3□ DOA P this 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 - Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HOS5(197 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 218 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Month 9:20 A.M Harvey H. Knight 7,_ December 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. P. G. Hospital Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 15,1929 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral 11X1M 2□ F 76 227-34-5083 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other than "naturel", or itema 23a or 28e-f ehow other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No P.G. Forestville Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 U.S.A. 1306 Alberta Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (图Yes. 2 □ No Korea If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U. S. Gov't 12 Admin. Asst. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Louise Foster John H. Knight ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: if item 27 is 1306 Alberta Dr., Forestville, MD 20747 Anne D. Knight/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: if it ony injury or c 1 ☑ Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) 12-13-2006 Brentwood, MD Ft. Lincoln Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home Meran 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC FATAL **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai attending physical for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the s 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D58957 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY VITTLE 3001 HOSFITAL 31. Date filed (Month Day, Year) 32. Registrar's Signature State DEC 12 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylar		artment of Hertificate of L		•	giene Reg. No. 006	41351
	Physici		1. Decedent's Name (First, Middle, Last) Mary E. Keys					2. Date of De Month Dec.	7, Day 2006	3. Time of Death 8:40A M
	/Medic Examin		4a. Facility Name (If not institution, give : Bradford Oaks N	street and number) Jursing Hom	e	4b. City, Town, or Clinto			4c. County of De. P. G.	
	Funeral Director		5. Social Security Number 6. Sec. 579-20-5804	7. Age (In yrs. 94	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir (Month, Da	ly, rear)	rthplace (State or Foreign country)
	thow		Usual Residence of Decedent 10a. State		ty, Town or Lo					10d. Inside City Limits
	th the Ma or 28a-f s e notifie	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	1 Yes 2 No Country?
	death w	neral	7817 Denton St	Was Decedent Ever in U Armed Forces?	I.S. 13.	20735 Was Decedent of His f Yes, specify Cubar	spanic Origin? (Specify Yes or No	U.S.A.	
9036	ours after rral', or its Examina	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🎛 No	Specify:	to riban, sto.)	Specify: B.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at ance.	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occupa kind of work done d DO NOT use retired) Entry	uring most of wo	orking	16b. Kind of Busines Federa	s/Industry l Governmen
and 2	d be filed v ntal Hygie ed other t	Be	12 17. Father's Name (First, Middle, Last) John West		2400				, Maiden Sumame)	
Mary	d 2 should th and Me t7 Is mark traumation	으	19a Informant's Name/Relationship (Ty. Barbara V. Mor	ов, Print) an Daughtei			nd Number or R	ural Route Numb	er, City or Town, State, n, Md. 2(
altimore,	ages 1 an int of Heal t: If Item 2 y or other		20a. Method of Disposition 1	emoval from State MC	Place of Dispo	sition (Name of natory or other place 11vet	Dec	Date 12 2006	20c. Location - City o	r Town, State
Baltir	permit. P Departme Importan any Injur		21. Signature of Funeral Service Licens	Emalis	22 F	Name and Address	4.5			D.C.20001 n St.N.W.
			23a. Party Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the dealer cause on each line.	th. Do not ent		, such as cardia	c or respiratory a		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consec			مر ۳۰۰۰			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):					
8760,	ficate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a consec	quence of):					
9	certificate iding phy se as the	00 1	IF FEMALE:	3c. If yes, outcome of pregn	ancv				22d Date of de	Nivos.
.O. Box	The law requires that the death certifi tte has been signed by the attending l age 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
٩.	uires that i signed by id be deta	by	Part II. Other significant conditions cor	tributing to death but not res	sulting in the u	nderlying cause give	n in Part I.	23e. Did t	obacco use contribute t	robably 4 Unknown
Records,	The law requirr ate has been si page 2 should b	Completed						24a. Was autor perfo		utopsy findings available completion of cause of
	siclan: Th certificate rector, pag	Be Co	25. Was case referred to medical examiner?					ath (Check only o		s 2 No
on of \	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p	tlon: To	27. Manner of Death 1 Panatural 5 Pending	ospital: 1 Inpatient 2 Inpatie	ER/Outpatien 28b. Time of Injury	28c. Injury Work	at at	_	dence 6 Other (Spanow injury occurred	ecify)
Division	f or Attenation after deation Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)		35 2	28f. Location (3 City or Tox	Street and Number or F vn, State)	iural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Check only one) 1 Medicel Exemi	sician: To the best of my knoter: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my op	e, date and plac inion, death occ	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of confider and willing and an arms.	ne h		29c. License			29d. Date signed (Mon	
)	(3)		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,	Print) ecton Risa	d Ent	١,42٨ -	noton mon	mlmt
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	>/*** 1-00	1 4-4-1	V=104.31	, , , , , , ,	10-6,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SUZANNE KUFF DECEMBER 8, 2006 12:45P /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner RENAISSANCE GARDENS SILVER SPRING MONTGOMERY If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🖫 F Hours 81 Director 04/24/1925 MARYLAND 215-28-7214 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 25a or 28a-f show ant: If item 27 is marked other than "naturon or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 17 Yes 2 □ No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? B158 GRACEFIELD ROAD APT 112 20904 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. ģ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 <u>PIANO TEACHER</u> PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM SEFF ၉ CECILE MANDELSTAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DR. EDWARD L. KUFF/HUSBAND 3158 GRACEFIELD ROAD APT112, SILVER SPRING, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State NATIONAL CREMATORIUM | 12/13/2006 | FALLS CHURCH, VIRGINIA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 21. Signature of Funeral Service Licensee 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RECTAL CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached i s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ DECUBITUS ULCER 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed SEPSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 1∐ Yes 2 🔀 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 XNatural Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D23645 DECEMBER 9, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14085 LITTLE PATUXENT PKWY, COLUMBIA, MARYLAND JOHN STUCKEY, 31. Date filed (Month, Day, 32 Registrar's Signature Year) State

Registrar

2006

DEC

			For State Registrar	tate of Ma	ryland / Depa <i>Cer</i>	irtment of H	lealth and D <i>eath</i>	d Mental Hyg	iene eg. No. 20	06 41353
6.0	Physici /Medic		1. Decedent's Name (First, Middle, Last) Hyun Tae Kim					2. Date of Dear	th	3. Time of Death 9006 6:16 P M
	Examir		4a. Facility Name (If not institution, give stre Montgomery General	,	1	4b. City, Town, or Olney		eath	4c. County o	f Death
	Funeral Director		5. Social Security Number 578-52-7172 Usual Residence of Decedent	7. Age 2 ☐ F	(In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days		8. Date of Birth lin. (Month, Day, June 11,	Year)	9. Birthplace (State or Foreign Country) Korea
sailmore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade co	Drive # Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: on mpleted) College (1-4or 5+) 5+ Print) ife	16a. Deced (Give life. E 19b. Mailing 15107 20b. Place of Disposemetery, even Gate of Hea	Spring 10f. Zip Code 209 Vas Decedent of Hi Yes, specify Cuba Yes, specify Cuba Yes 2 No ent's Usual Occupe kind of work done of O NOT use retired Teprene ur Address (Street a Tinteria ittion (Name of atory or other place kind of yes wen Cemeter Name and Addres Tancis Amenand Addres Tancis Amenand Addres Tancis Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Termand Term	spanic Origin? n, Mexican, Pu Specify: ation luring most of v 18. Mother's N Ah Yur and Number or chen Dr chen Dr s of Faqiility in	(Specify Yes or No- uerto Rican, etc.) Working Name (First, Middle, Mana Route Number, 1901 Date ember 9, 2006 as Funeral	Black, Specifics 16b. Kind of Busi Busines Maiden Surname, City or Town, S 6, Silve 20c. Location - C ilver Sr Home Ir	- American Indian, , White, etc. sian iness/Industry ss tate, Zip Code) er Spring, MD 20 ity or Town, State
Division of vital necolus, F.C. Box 66/60,	res t igne	Medical Certification: To Be Completed by Physician/Medical Examiner	in the past 12 months? 1	Due to or as a concept of the concep	consequence of): pregnancy pregnancy pregnancy prediction of death 5 and resulting in the unce of death 5 At home, farm, strees Specify) The specify of the street The specific of the street The specific of the street The specific of the street The specific of the street The specific of the street The specific of the street The specific of the street The specific of the street The specific of the street The specific of the street The street of the	Ectopic pregnancy Other (specify) Bell DOA Other (specify) Bell Injury M 28c. Injury Work 1 Yet, factory, office	n in Part I. 26. Place of D T: 4 \(\text{Nursing} \) at? es 2 \(\text{No} \) e, date and pla inion, death oc	23e. Did tob 1	23d. Date Month acco use contrib s 2 No 3 24b. We prive dea 1 certain No 1 certain Number w injury occurred eet and Number State) use(s) and mannate and place, and	ute to the cause of death? Probably 4 Unknown ere autopsy findings available or to completion of cause of ath? Yes 2 No (Specify) or Rural Route Number,
			30. Name and address of person who completed Kung (Month, Day, Year)	eted cause of deat	h (Item 23a) (Type, P	Philip D	y Olne	29 24 MD 20	147/	06
	Sta Registra		DEC 11 2006	Salve .	15 per					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Ola Mae Lloyd Kelsoe December 2006 2:30 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3414 Wake Drive Montgomery Kensington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 87 1919 Alabama Apr. 14, Director 422-96-8864 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural" or items 23a or 28a-f show any lighty or other traumatic event, the Medical Examinar mind of the any or other traumatic event, the Medical Examinar mind of the any of the straumatic event, the Medical Examinar mind of the any of the straumatic event, the Medical Examinar mind of the any of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Maryland of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event, the Medical Examinar mind of the straumatic event mind of the straumatic event mind of the straumatic event mind of the straumatic event mind of the straumatic event mind of the straumatic event mind of the straumatic event mind of the straumatic event mind eve 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 U. S. A. 3414 Wake Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Augusta Penalton Matthews John Lloyd ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Enright - Daughter 3414 Wake Drive, Kensington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RFD. McKenzie, 12/11/2006 Antioch Cemetery Alabama 21. Signature of Funeral Service Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852 Donald 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed Atrial Fibrillation the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Stroke IF FEMALE nse 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by been signe should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 ☐ No 2 XNo or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 [XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

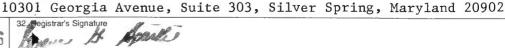
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DEC 1 1 200

Dr. Vinu Ganti

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D0061146.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** MILTON DECEMBER 9, KAUFMAN 11:00 P M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 ☐ F 95 579-44-2387 Director 02/17/1911 NEW YORK Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 √Yes 2 No Director "NONE" DC WASHINGTON 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? "natural", or items 23a or edical Examiner must be r 4000 MASSACHUSETTES AVENUE, NW 20016 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the M Elementary/Secondary (0-12) College (1-4or 5+) 5+ CIVIL SERVANT US GOVENMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH KAUFMAN SERINA KLEIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HUGH KAUFMAN 1219 4TH STREET, SW, WASHINGTON, DC SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or KING DAVID MEML GDNS 12/11/2006 FALLS CHURCH, VIRGINIA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 21. Signature of Funeral Service Licensee INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARÝLAND 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIAC ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the a 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed FAILURE TO THRIVE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 X No SENILE DEMENTIA 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Certification: 28b. Time of 28d. Describe how injury occurred Year) 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD1940S DECEMBER 10, 2006 0001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. J.R. HOLLOWAY, KAISER PERMANENTE, 10810 CONNECTICUT AVE, KENSINGTON, MD 20895 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

			1 - State of I	Maryland / Depa	artment of F			200	6 1.1356
	200		Registrar 1. Decedent's Name (First, Middle, Last)		Timodic of	Death	2. Date of Deat		3. Time of Death
8	Physici /Medi		Effie Lynard Kalcounos	5			Decembe	r 6, 2006	
100	Examir		4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, o	r Location of Death		4c. County of De	eath
			17015 Moss Side Lane	A (I A bidled	Olney If Under 1 Year	If Under 24 Hrs.	10.00	Montgom	
	Funeral Director		578-13-6714 1□M 2対F	Age (In yrs. last birthday) 88 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, April 17	Year)	Birthplace (State or Foreign Country) ashington, DC
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 22 If Yes, Give Year or Date	s? ☑ No	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2☐No	dispanic Origin? (Sp. an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ai Black, W Spewiat	
21215-0036	within 72 ho ene. than "natur ne Medira	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	or 5+) (Give		oation during most of work d)	ing	16b. Kind of Busines	,
	filed Hygic		17. Father's Name (First, Middle, Last)	sale	s Clerk	18. Mother's Name		oodward & Maiden Surname)	Lothrop
Maryland	lid be fental rked c	To Be	Constantine Lynard				a Dounis	,	
ary	shou and N s mar	-	19a. Informant's Name/Relationship (Type. Print)			and Number or Run			
	and 2 fealth a m 27 is		C. Nicholas Kalcounos/ Son			Drive, Si		ing, MD 2	0904
Baltimore,	Pages 1 ent of H nt: If ite y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te 20b. Place of Dispo cemetery, cre.	matory or other pla	Decem	ber 9,	20c. Location - City	,
Salti	permit. F Departm Importar any injur		21. Signatur 1 Funeral Service Licensee	F	2. Name and Addre	200 : ess of Facility Collins	Funeral	ashington Home Inc	
-	205 # 2		under Cole	5	00 Unive	rsity Blvo	d, W., S	ilver Spr	ing, MD 20901
	Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underwring Cause (Disease or injury that initiated events	sclerotic Ca as a consequence of): as a consequence of):					Approximate Interval Between Onset and Death
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Records, P.	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	by	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 □Unknown
al Reco		Completed				······	24a. Was an autopsy perform 1□ Yes 2	/ prior t	
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		ot 3 DCA Oth	26. Place of Death			
ō		<u>۔۔</u>	27. Manner of Death 28a. Date of In	njury 28b. Time o	IL JUDON	4 L Nursing Ho	me 5 E Resider 28d. Describe how	nce 6 Other (Sp	pecify)
Division or	To the Hospital or Attending Prwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be	Day Year) Injury injury - At home, farm, stretc. (Specify)	M 1 1	Yes 2 □ No		eet and Number or	Rural Route Number,
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	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the be 2 ☐ Medical Examiner: On the basis and manner	s of examination and/or in	th occurred at the till evestigation, in my o	me, date and place, ppinion, death occur	and due to the ca red at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
)	To the within 2 To the complex	Ž	29b. Signature and title of certifier Maetha I Saav	edra	29c. Licens	e number		d. Date signed (Mo ecember 7	-
_			30. Name and address of person who completed cause of Martha Saavedra, M.D.	10301 Georg	ia Avenue	e, #301, S	Silver Sp	oring, MD	20910
	Sta Registr	- 23	31. Date filed (Month, Day, Year) DEC 1 1 2006	strar's Signature	de)				

DHMH 17 Rev 1/2001

Registrar

		For State Ragistrar		/ Depa	artment of Health and tificate of Death	Mental Hygie		41358		
Physic /Med		Decedent's Name (First, Middle, Las Thelma Broha				2. Date of Death Month	Day Year			
Exam	iner	4a. Facility Name (If not institution, give CORCHESTER 6 5. Social Security Number 6. Se	ENERAL	t birthday)	4b. City, Town, or Location of Deat AMBRIDGE If Under 1 Year If Under 24 Hrs	h	4c. County of Dea	ath HESTER		
Directo		Usual Residence of Decedent	_M 2½F 88	Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y March 9	,1918 M	rthplace (State or Foreign ountry) aryland		
the Maryland 28a-f show	Director	10a. State 10b. County MD Dorche 10e. Street and Number	ster 10c. City, 1	Town or Lo	Vienna		10d. Inside City Limit			
death with	Funeral Dir	109 Gay Street	12. Was Decedent Ever in U.S.	12.1	10f. Zip Code 21613		USA 14. Race - Am			
or Its	b	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerl □ Yes 2⊠No Specify:	pecify tes of No- o Rican, etc.)	Black, Wh			
21215-0036 od within 72 hours atter gjene. or then "naturel", or lite	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation to completed) College (1-4or 5+)	16a. Deced (Give life. L	ent's Usual Occupation kind of work done during most of wor DO NOT use retired) homemaker	rking 16	b. Kind of Business			
be filed half Hyging of other	To Be Co	17. Father's Name (First, Middle, Last) Riley Willey			18. Mother's Nar	Own home Mother's Name (First, Middle, Maiden Sumarne) Elsie Willey				
b, Maryle and 2 should ealth and Mer m 27 is marks		19a. Informant's Name/Relationship (Type, Print) Wayne Brohawn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 5203 Beaver Neck Village Rd., Linkwood,								
Baltimore, permit. Pages 1 a Department of Her mportent: If them any Injury or other more.		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	Doro	heste		/13/06	c. Location - City of Cambridge	, MD		
Balti permit. Departin Importe any Inju	de Sa	21. Signature in Funeral Service Licens	~	7	Name and Address of Facility T	ambridge,	MD 2161.			
Physician /Medica Examiner		23a. Part (/Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	2/4	Shock			Approximate Interval Between Onset and Death		
58760, icate be executed physicien end s the burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent of the total of t	A	1 In Sarctio					
I Records, P.O. Box 687 The law requires thet the death certificate are has been signed by the ettending phy page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year		
cords, P	b	Part II. Other significant conditions co	ntributing to death but not resulting		derlying cause given in Part I.	23e. Did tobac	_	o the cause of death?		
Vital Records, sician: The law requires to certificate hes been signer rector, page 2 should be continued.	Completed	,				24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of 2 100		
Phys ratel	ation: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Outpatient b. Time of Injury	0.4	th (Check only one) ome 5 Residence 28d. Describe how		icify)		
Division Hospital or Attending 14 hours after death. Funaral Director: After	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office	28f. Location (Stree City or Town, S	t and Number or Ri State)	ural Route Number,		
the side	Medical	one) 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time, date and place estigation, in my opinion, death occur	red at the time, date	and place, and due	e to the cause(s)		
To with To Con	4	29b. Signature and title of certified	200		29c. License number	1:	Date signed (Mont			
		Eugene Nei	ompleted cause of death (Item 23)	503 Byn	St Ca.	nbords	e MD 2161		
St Regist	ate trar	31. Date filed (Month, Day, Year) DEC 1 1 2006	32. Registrar's Signature	Prove	r e					

06-09521 John Knott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle Last) Medical Examiner JOHN LOUIS KNOTT December 13, 2006 0200 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Civista Medical Cemter La Plata Charles 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director 216-70-8777 Months Days Hours $_{1}XX_{0}$ 2 F 46 oreign FEB.8.1960 MARYLAN Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Menial Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho MARYLAND Director CHARLES LA PLATA 1 X XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 626 HEMLOCK COURT <u> 20646</u> Funeral Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black 1 Never Married Married Armed Forces? White, etc. Yes 2 **XX**No Widowed 4 X X Divorced If Yes, Give Year ş 1 Yes 2 X XNo specify Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical Exan 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry Elementary/Secondary (0-12) during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 12 LABORER/DETAILER HUNT FORD DEALER 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) JOSEPH LEROY KNOTT, SR. Be MARY FRANCES BAKER 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAYLE JOHNSON-SISTER PRESTON LANE POMFRET 20a. Method of Disposition MD 20675 20b. Place of Disposition (Name of cemetery, 1 XXurial 2 Cremation 3 Removal from State crematory or other place) Important; Donation 5 SACRED HEART CH.CEM. 12-21-06 LA PLATA, Other Specify. 21. Signature of Funeral Service Licensee Me 0 4 79 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 3a. Part I. Enter the disease, or complications hat caused the death. Denot enter into hod 12/31 from as 14/31 fro Physician failure. List only one cause on each line Approximate Interval /Medical **Fxaminer** Immediate Cause (Final disease Atherosclerotic cardiovascular disease Death or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and sician/Medical X UNPENDED AMENDED #23a,27,perME, Box 68760, g863. 1/5/07 TT 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth Fetal death 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Phy Unknown Part II. Other significant conditions Ö contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò σ. Completed 1 Yes 2 No 3 Probably 4 Unknown Records, peen 24a Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of performed death? ✓ Yes 2 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25 Was case referred to medical Division of Vital Be 26.Place of Death (Check only one) examiner? Other₄ Inpatient 2 V ER/Outpatient 3 1 🗸 Yes DOA Nursing Home 5 Residence 6 Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural 5 Pending r death. Director: the 1 Yes 2 No 2 ___ Accident Investigation 24 hours after e Funeral Direc 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo O.C.M.E. December 14, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Ling Li, MD 111 Penn Street, Baltimore, MD 21201 State 32. Registrar's Signature 2006 2500 Registra

DHMH 17 Rev 1/2001 OCME 2006

06-09582	
Gary Dean Kole	

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ Decedent's Name (First, Middle, Last) 2. Date of Death Month Day December 15, 2006 **Medical Examiner** 1805 hrs Gary Dean Kole 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 25822 Whiskey Creek Road Hollywood St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Director 07/09/1951 CountryNew Jersey 1 X M 2 F 55 152-40-8441 Usual Residence of Decedent any 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 XNo 28a-f show St. Mary's Hollywood Maryland permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important; If item 27 is marked other than "natural", or items 23a or 28a-f sht injury or other reaumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 20636 United States 25822 Whiskey Creek Road 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funera If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc Never Married 2 X Married Yes Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Automotive Salesman 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Virginia Grovesnor Joseph John Kole ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20636 25822 Whiskey Creek Road, Hollywood, MD Deborah Minnich Kole/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/21/2006 Charlotte Hall, MD Brinsfield-Echols Cr. Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. MU1206 22955 Hollywood Rd., Leonardtown, MD 20650-0279 Kyle S. Simons Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical XUNPENDED AMENDED attending physician or use as the burial #23a,27,perME Box 68760. IF FEMALE 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been a 24a. Was an 24b. Were autopsy findinos available autopsy prior to completion of cause of performed? death? page ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical director, Be Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other Scene 1 V Yes No 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending death. Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Fo the Funeral 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 16, 2006 DR. Name and address of person who completed value of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) *■*egistrar's Signature State DEC Registra

		1 - For Amend It Registrar		25,27,2	Ba-f p	er ME	G863 rtifica	01/1	Death	dhb	ieniai ny	Reg. No	200	6	41361
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Examir	ner	4a. Facility Name (If not instituti			er)			olney	Location o	or Death		40	Mon:	taom	077
Euroval		4217 Queen 5. Social Security Number	6. Sex		Age (In yrs.	last birthday	-	r 1 Year	If Under	24 Hrs.	8. Date of Bir	th	PIOII		place (State or Foreign
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D D		Usual Residence of Decedent													
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-1 show many injury or other traumatic event, the Medical Examinar must be multiled at ouce.	by Funeral Director	11. Marital Status 1 □ Never Married 2★ Ma 3 □ Widowed 4 □ Divorce	arried	 Was Decede Armed Force Yes 2 If Yes, Give Year or Date 	es? □NoWW	II	If Yes, spe		Specify:		ecify Yes or No Rican, etc.)	-		, White,	ean Indian, etc. hite
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Haltimore, bermit. Pages 1 ar Department of Hea proportant: If Nem. Any injury or othe		20a. Method of Disposition				Place of Disp cemetery, cre	osition (Na	me of	ا ده	C	Date	20c. Lo	ocation - C	ity or To	own, State
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ס ≒	iner	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	Directo (or	as a gunseo	(luence of):			-	- 7	EXEX	MINE			
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, P.O. BOX 68/60, that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	2.0	1 ☐ Live birth 4 ☐ Pregnan	1 2 ☐ Feta	al death 3	□Ectopic p					Ī	23d. Date Mont		ery Day Year
hat the do do do by the detached	issic	1 □ Yes 2 □ No 9 □ Unknown		9☐ Unknown		ibatii 5	_ Other (s)	oochy)							
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Of Vital Physician: rthis certificaral director,	To B	examiner? 1 XYes 2 No	-	ospital:	atient 2 🗆	ER/Outpatie	nt 3∏ D	OA Othe			me 5 Resid		6 □Other	(Specifi	w)
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DIVISION OF VITAL RECORDS, if or Attending Physician: The law requires taler death. Director: Atter this certificate has been signed in by the funeral director, page 2 should be	Certification:	3 ☐ Suicide 6 ☐ Coul. 4 ☐ Homicide deter	d not be mined	28e. Place of	Injury - At h etc. (Specia	ome, farm, s	treet, factor	y, office			28f. Location (5 City or Tox	Street an vn. State	d Number	or Rura	I Route Number, MD
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UNISION To the Hospital or Attending I within 24 hours after death To the Funeral Director: Atter completely filled in by the funer	edicai	29a. Certifier 1 ☐ Certify (Check only 2 ☐ Medical one)	ing Physi al Examin	er: On the basis	s of examina	owledge, dea ation and/or i	th occurred nvestigation	at the time, in my or	ie, date an pinion, dea	d place, th occurr	and due to the e	cause(s) date and	and man place, ar	ner as st id due to	ated. the cause(s)
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15+1		30. Name and address of perso	n who cor	npleted cause of	of death (Iter	n 23a) (Type	, Print)								
		John G. Lodr	nell,	M.D.	2901	Olney	-	, Oli	ney,	Mary	land	2083	32		
Sta Regista		31. Date filed (Month, Day, Yea DEC 1		- 60	istrar's Signa	K A	marks	•							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Day Year December 5, 2006 **Physician** 10:00 A. May S. Leiner /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Locetion of Death 4c. County of Death **Examiner** 3210 N. Leisure World Blvd., # 511 Silver Spring Montgomery 8. Date of Birth (Month, Day, Yeer) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Yrs. Director 255-24-8525 Georgia Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health end Mentel Hygiene. Important: if Item 27 is marked other then "netural", or items 23a or 28a-f show enty injury or other treumetic event, the Medical Examiner trust be inclined at enter. 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No Maryland Silver Spring Director Montgomery 10e Street end Number 10f. Zip Code 10g. Citizen of What Country? 20906 U. S. A. 3210 N. Leisure World Blvd., # 511 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Railroad 12 Years Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lena Freedman ပ္ Abraham Shapiro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane L. Benson - Daughter 9529 Reach Road, Potomac, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gdns 12/8/2006 Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. us 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Sudden cardiac Immediate Examiner Due to (or as e consequence of): Physician/Medical Examiner antery I or Attending Physicien: The law requires that the death certificate be executed the death.

Director: After this certificate has been signed by the ettending physicien and in by the Innerial director, page 2 should be deteched for use as the buriel-transit physicien end s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760, hypertensi Due to (or as a consequence of): resulting in death) Lest Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ete hes been signed by the opage 2 should be deteched 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown obstructive pulmonum Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 NResidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 🗆 Homicide To the Hospital or within 24 hours e To the Funerei D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 612 D500 Decembe 5, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3305 North Leibre world Bushward Silver Spring MD 2090 & G. MALLER MP 31. Date filed (Month, Day, Year) 32 Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

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2006

Physician

/Medical

Examiner

10a. State

PA

Funeral Director

Be Completed by

Funeral

Director

the Medical Examiner

or other traumatic event,

Department of Heal Important: If item 2 any injury or other

Physician

/Medical **Examiner**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 09 Month 12 06 10:41AM RONALD CECIL LEPLEY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WMHS- BRADDOCK CAMPUS CUMBERLAND 9. Birthplace (State or Foreign Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 1XM 2□ F 69 170-30-0511 Yrs. 7-29-1937 WELLERSBURG, PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No SOMERSET MEYERSDALE 10e. Street and Number 10g. Citizen of What Country? 6478 1555a USA LUMBERLAND 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION 10 DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HENLY LEPLEY GLADYS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE CUMBERLAND LEPLEY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 12-15-2006 4 □ Donation 5 □ Other (Specify) LAWN MEMORIAL 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 169 HARVEY H. ZEXGLER F.H. HYNDMAN, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death 30 M/~ RONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed burial-transit after death. the

Physician/Medical Examiner

Be Completed by

IF FFMALE

29a. Certifier

completely filled in by To the Hospital within 24 hours at To the Funeral C

Medical Certification: To 15/3/1

nes State

Registrar

pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Under the date and place and place, and due to the cause(s) and manner as stated. and manner stated 29b. Signature and title of certifier 441

Cumberland

29d. Date signed [Month, Day, Year)

pleted cause of death (Item 23a) (Type, Print) 30. Name at address of person who cor Eugene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 👂 🗋 🧂 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау Month Year **Physician** Arlene (NMN) Lawrence December 14, 2006 6:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 13705 Oakleaf Drive Cumberland Allegany 8. Date of Birth (Month, Day, Year) 03/13/1945 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F 61 Yrs. New Jersey Director 144-36-9315 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location show 10d. Inside City Limits other traumatic event, the bludical Examinar must be notified at Allegany Cumberland 1 ☐ Yes 2 X No Director 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 13705 Oakleaf Drive 21502 USA or items 23a Funeral 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Child Care 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be if Health and Mental item 27 is marked o Pages 1 and 2 should be Donald Warren Dawson Holt June Evelvn 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry R. Lawrence / husband 13705 Oakleaf Drive, Cumberland, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/18/2006 Cumberland, MD Memorial Park Sunset 21. Signature Fur eral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Vari resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ☐Yes 2☐No 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be c Completed by of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 | Inpatient 1 ☐ Yes 2 ☐ № Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ို 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Division 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Att completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🖺 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D36766 December 14, 2006 5

State Registrar 31. Date filed (Month, Day, Year) 14

30. Name and address of person who complet = cause of death (Item 23a) (Type, Print)

32. Aggistrar's Signature

nes

21502

Vik Poonai, M.D., 924 Seton Drive, Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene 2 Amend 1 Lem 23a per dr. 8865.03/29/0/dab 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ALICE M. LEWIS December 11, 2506 4c. County of Death 1856 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Peninsula Regional medical Center Wicomico Date of Birth (Month, Day, Year 08/03/41 Birthplace (State or Foreign Country)
 VA Age (In vrs. last birthday **Funeral** 1 □ M 2 🛣 F Months Days Hours Min 230-50-4018 65 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10h County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Accomack Temperanceville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23442 25417 Saxis Rd. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Woodrow W. Harris Estelle Holden 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25417 Saxis Rd., Temperanceville, VA 23442 Theodore Lewis, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State Groton Community Cem. 12/16/06 Messongo, VA 4 □ Donation 5 □ Other (Spec 22. Name and Address of Facility of Fung Cooper & Humbles Funeral Co., Accomac, VA ant I. Enter the ississe, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart plante. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician Seauce disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🎝 No the 9 Unknown been signed by should be detac ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 € No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed?

1 Yes 2 X No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1/2 Inpatient After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed ca

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31. Date filed (Month, Day,

BAI

Salisbury MD

se of death (Item 23a) (Type, Print)

Carroll

Registrar's Signature

			1 - For State Registrar	State of	f Marylai		artment of H rtificate of L			ene g. No.2 0 0	6	41366
			1. Decedent's Name (First, Middle, Las	st)				· · · · · · · · · · · · · · · · · · ·	2. Date of Death	1		3. Time of Death
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	Examir		4a. Facility Name (If not institution, giv-	e street and nur	nber)		4b. Cily, Town, or	Location of Death	1	4c. County of	Death	
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	Funeral		Social Security Number 6. S	ex □M 2⊠F		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) S	9. Birthplac	e (State or Foreign
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	and w		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation				10d	Inside City Limits
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28a-f ehow any injury or other treumatic event. The Medical Exactifical must be rightled at ODGs.	by Fur	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed For 1 Tes If Yes, Giv Year or Da	2 🔀 No e		f Yes, specify Cubar 1 □ Yes 2⊠ No	n, Mexican, Puerto Specify:	Rican, etc.)		White, etc	
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<u> </u>	uld b Vents rked rice	To E	Walter	Hickman					Lula Bar	row		
Maryland	and I		19a. Informant's Name/Relationship (Гуре, Print)		19b. Mailin	g Address (Street a	nd Number or Ru	ral Route Number,	City or Town, St	ate, Zip Co	ode)
	and alth		Tony E. Little (son)		31 R	oosevelt	Ave., Ap	t. A2, A	oerdeen,	MD	21001
altimore,	of Her		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Pamoval from 9	- 1	Place of Dispo cemetery, cren	sition (Name of natory or other place	9)	Date 2	0c. Location - Ci	ty or Town	, State
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Ball	permit. Depart Import any inj		21. Signature of Funeral Service Licen	560	JAN Y	L ²²	Name and Address e A. Patt	s of Facility Cerson & Marylar	Son Fune	ral Home	e, P.	Α.
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<u> </u>	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					26. Place of Deat	h (Check only one			3.10
<u> </u>	hysic his ce I dire	10	1 ☐ Yes 2 No	Hospital: 1 XIII	patient 2	ER/Outpatien	3 DOA Othe	r: 4 🗆 Nursing Ho	ome 5 Residen	ce 6 Other	(Specify)	
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DIVISION	of or Attend efter death Director: , d in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place	of Injury - At h g, etc. (Speci	ome, farm, stre fy)	eet, factory, office		28f. Location (Stre City or Town,	et and Number (State)	or Rural Ro	oute Number,
	To the Hospital within 24 hours e To the Funeral Completely filled	Medicai C	(Check only 2 Medical Exam	iiner: On the ba	sis of examina	owledge, death	occurred at the time estigation, in my opi	e, date and place, inion, death occur	and due to the cau	ise(s) and manne	er as state	d. e cause(s)
	the thin 2 the mplei	Med	29b. Signature and title of certifier	and mann	er stated.		29c. License					
)	F ≥ F 8		295. Signature and the or certifier	w	MD		25C. CICHISH	2600	290	d. Date signed (A	vionin, Day	r, rear)
			, , , , , , , , , , , , , , , , , , , ,					001		101	06	
5			Name and address of person who of	Milha	of death (Iter	n 23a) (Type, 1	Print)	on St. t	Parno	e Grace	1 m	121078
	Sta		31. Date filed (Month, Day, Year)	32.Ae	gistrar's Signa							
E	Registra	ar	DEC 1 2 20	UD Z	BULL O	CP 60	3486					

			1 - For State Registrar	State of I	Marylaı		artmen <i>rtificat</i>			and M	lental Hy	/giene	201)6		367
	Physici	an	Decedent's Name (First, Middle, Total		- 1	, .					2. Date of De Month	eath Da	у `	/ear	3. Time o	of Death
Jack	/Medi	cal	Jea: 4a. Facility Name (If not institution,	n Christin		hart	4h City	Town or I	Location o	of Death	Decemb		3, 20 County of		035	5 M
	Examil	ier	Laurelwood Ca		,		10.04,		kton	n Douth		40	•	Ceci	1	
	Funeral			6. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs.	. last birthday)	If Under Months		If Under	24 Hrs. Min.	8. Date of Bi (Month, D	rth			lace (State	or Foreign
	Director		213-66-7208 Usual Residence of Decedent	TOM ZEAF	81	Yrs.		04,0			March 20		25		ryland	
	yland		10a. State 10b. County		10c. C	ity, Town or Lo	cation							1	0d. Inside 0	City Limits
	e Mar	ctor	Maryland Cec	:11			Port :	Depos	sit						1 🗌 Yes	s 2 ∑ No
	vith th	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of Wh	at Cour	ntry?	
	eath v	eral	201 Funk Road	12. Was Decede	ent Ever in I	18 12 1	Was Daged		2190					S.A.		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event. The Modical Examiner must be notified at once.	by Funeral	1 Never Married 2 Marrie 3 Widowed 4 💆 Divorced	Armed Force	ss? XX No		f Yes, spec			, Puerto	ecify Yes or Ne Rican, etc.)	0-	14. Race - Black, Specify:	White,		
5	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usua kind of wor	l Occupat	tion	of works	na		ind of Busi			
Maryland 21215-0036	within ne. han	Completed	Elementary/Secondary (0-12) Twelve Years	College (1-40	or 5+)	life.	DO NOT us	e retired)	_	OF WORK		1			_	Ground
2	filled v Hygie other f		17. Father's Name (First, Middle, La	ast)			Sec	reta		r's Name	(First, Middle	1			ryland	a
<u>a</u>	lid be fental rked c	To Be	013	Lie Whitake	er						Pearl		ŕ			
ary	and Notes		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	g Address	(Street an	nd Numbe	r or Rura	l Route Numb	er, City o	r Town, St	ate, Zip	Code)	
≥ ത്	l and lealth im 27 iher tr			son)	005						, Alab			466		
000	nt of h		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		10	Place of Dispo					ate		cation - Ci	-		
Baltimore,	artme ortani injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Li		A	sbury C	. Name and	-		12/1:	2/06	Port	Depo	sit	, Mar	yland
ä	Dep Per Per Per Per Per Per Per Per Per Per		Shower h	taller	TON, S	Le Le	e A.	Patt	ersor	n & 3	Son Fun	eral	. Home	e, P	.A.	
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that caus	sed the deal	th. Do not enti	er the mode	of dying,	such as o	cardiac o	r respiratory a	rrest,	00		Approxima Interval Be	te tween
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a OU	610A	UELLOC	SLION	4	- 1	300	IN TO	عبرد	2		Onset and	Death
S.	/Medical Examiner		roodkiing an dodkinj	Due to (or a	as a consec	quence of);										
		Jer	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a consec	quelice of).				-				-		
	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										Щ		
8/60,	icate be executed physician and s the burial-transit	E	resulting in death) Last	Due to (or a	as a conseq	quence of):										
289	certificate be executed iding physician and ise as the burial-transit	edlcal		d.												
ŏ	eath certific ettending p for use as	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom									23d. Date o	of delive	rv	
o C	e death the etter	Physician/Me	in the past 12 months? 1 🗆 Yes 2 🗀 No	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	at time of d		Ectopic pre Other (spe						Month		Day	Year
7.	hat the de od by the de detached	Phy	9 ☐ Unknown Part II. Other significant conditions			rulting in the un	doshio z oo		in Book		00- Bid					
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Cord	law requir as been si 2 should b	lete	HIDOM								24a. Was			re auton	sy findings	avadable
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	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	4				2	26. Place o	of Death	Check only o	2. No	'	Yes	2 No	_
5	\$ w = 0	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa		ER/Outpatient		Other	▲ Nurs	sing Hom	ne 5⊡ Resid	denc <i>e</i> 6	Other (Specify,)	
<u></u>	ding h. After fune	tlon	27. Manner of Death 1	28a. Date of n	Jury Day Year)	28b. Time of Injury	28 M	c. Injury a Work?	ıt os 2∐N	2	8d. Describe I	now injur	occurred			
DIVISION	al or Attending after death. I Director: After d in by the fune	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	t be 1.8e. Place of I	njury - At he	ome, farm, stre			5 Z IV	-	8f. Location (S	Street and	d Number o	or Rural	Route Num	nber.
-	7 2 7 6	Cert	↑ □ Homicide	building,	etc."(<i>Specif</i>	(Y)					City or Tov	vn, State)				l)
	To the Hospital or Atten within 24 hours after deati To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical E	sician: To the best iner: O he basis d manner s	or examina	owledge, death ition and/or inv	estigation, i	the time, in my opin	data and nion, death	place, a occurre	d at the time,	date and	place, and	due to	ited. the cause(s	s)
	To t To t	≊	29b. Signature and title of certifier	1			1	License n		2			signed (A		Day, Year)	
		0	/11/	EU.			L	っつか	073	2		08	BDEC			
	6		30. Name and address / person wh	o completed cause of	death (Iten	n 23a) (Type, F	Print) [MAN	۲)	7/	<i>\$1</i>	Physi	715	n)	-	1972	20
Ĺ	Sta	e	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	iture	V 4		- / (IH						
	Registra	ar	DEC 1-2 200	6 Sees	, js	COOK!										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Elizabeth 852 PM athleen LE56 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner NIA 0+ Maryland MO Galhmore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 10/12/1960 215-80-8597 46 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show be notified Director MD OUEEN ANNE'S CHESTER 1 ☐ Yes 2√☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 413 MERGANSER COURT 21619 USA ortant: If item 27 Is marked other than "natural", or items 23a injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien. Important: If Item 27 Is marked other the any Injury or other trainmant. DELEGATION ASSISTANT GOVERNMENT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CALVIN DERR MCHENRY JOAN ELIZABETH SAPP ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JULIE DELCIOTTO/SISTER 142 CLEAR SPRING PLACE, MILLINGTON, MD 21651 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 12/12/2006 STEVENSVILLE, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 2. Name and Address of Facility FELLOWS, HEFENBEIN AND NEWNAM FUNERA 130 SPEER ROAD, CHESTERTOWN, MD 21020 HOME, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. p oximate terval Between nset and Death Immediate Cause (Final disease or condition resulting in death) Physician &B hows /Medical Due to (or as a consequence of): Examiner hows Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner hows requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. physician days Physician/Medical the as IF FEMALE: use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 → Yes 2 □ No for Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy perform Division or Vital 1∐ Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 ☐ Pending investigation Injury 1 Natural thin 24 hours arter control of the Funeral Director: After the funeral by the funeral of the funeral f Subjects uterus izertorate 2 Accident 3 ☐ Suicide 1 Yes 2 No UNK 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Towg, State) 4 ☐ Homicide Anne Hundel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

To the H within 24

State Registrar

9c. License number

DEC 8 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Freene Street Baltimare MOZ

31. Date filed (Month, Day, Year) 32. Registar's Signature DEC 12 2006

Back

		1 - For State Registrar	State of Maryla			t of Health an e of Death		Reg. No 2 0 0 6	5 4136
Physici /Medio		1. Decedent's Name <i>(First, Middle, La:</i> Kathryn Poul	•				2. Date of De Month Decemb	Day Yea	3. Time of Deat 2: 20 p
Examir		4a. Facility Name (If not institution, give 1000 Ross Thumb	r			Town, or Location of D Cambridge		4c. County of De	<u>+</u>
Funeral Director		5. Social Security Number 6. S 214-56-1359 Usual Residence of Decedent	9X 7. Age (In yi	s. last birthday) 56 ^{Yrs.}	If Under Months	1 Year If Under 24	Hrs. 8. Date of Bir Min. (Month, Da Octobe		irthplace (State or For Country) Maryland
ied at	tor	10a. State 10b. County Maryland Dorche		City, Town or Lo		mbridge			10d. Inside City Lir 1 ☐ Yes 2 ☑
a or 28s	Direc	10e. Street and Number 1000 Ross Thumb R			10f. Zip		2	10g. Citizen of What C	Country?
ital Hygiene. ed other than "natural", or items 23a or 28a-f ehow event, tra Medical Everuirar musi be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Deced f Yes, spec 1 ☐ Yes 2	lent of Hispanic Origin? ify Cuban, Mexican, Pi		- 14. Race - An Black, Wh	nerican Indian, nite, etc.
ene. than "natural", or items 23a or 28a-f ehow ta Medical Evanitat fraust be notified at	Completed by	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	Il Occupation of done during most of the retired)	working	16b. Kind of Busines	hite s/Industry
od other	Be	12 17. Father's Name (First, Middle, Last) Charles Henr	2		Nurs	18. Mother's I	Name (First, Middle, elyn Fore	Maiden Sumame)	ealth Care
alth and Menta	T _o	19a. Informant's Name/Relationship (7) Henry Fischer Sei	ype, Print)			(Street and Number of Thumb Rd.	Rural Route Numbe	er, City or Town, State,	
ment of Healt lant: If item 2 lury or other	- (3)	20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Va	Place of Dispo	sition (Nam		Date	20c. Location - City o	r Town, State
Department Important: eny injury c once.		A Signature of Furfers Service Licen-	Some la mueu	ee 3	Name and	er st., Ca	Funeral H	me, 21613	
ysician Medical caminer		23. Part1. Enter the discusse, or compositions, or high at latture. List only of immediate Cause (Final disease or condition resulting in death)	aDue to (or as a conse	all c	er the mode	of dying, such as card	liac or respiratory ar	rest,	Approximate Interval Between Onset and Deat
hysicien and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.						
ittending p	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preging 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pre Other (spe			23d. Date of de Month	elivery Day Year
in signed by the a uld be detached f	ed by Ph	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	derlying ca	use given in Part I.	23e. Did to	bacco dise contribute t	o the cause of death
After this certificate has been si funeral director, page 2 should	Completed						24a. Was a autop perfor 1 □ Yes	med? prior to death?	utopsy findings avail completion of cause s 2 \(\text{No} \)
directo	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatient	3□ DOA	Othor	eath Check only or	ence 6 □Other (Spe	20/64
tor: After the the funeral	ation:	27. Mann of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28 M	c. Injury at Work?		ow injury occurred	
within 24 fours and deat	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At l building, etc. (Spec	ify)			City or Town		
within 24 hours a To the Funeral is completely filled	ledicai	29a. Certifier 1 Certifying Phy check only one) 1 Medical Exami	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred a estigation, i	t the time, date and pla in my opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
To	Σ	29b. Signature and title of certifier	•		~	License number	7	9d. Date signed (Mont	
		30 Name an address of person who co	ompleted cause of death (Ite	m 23a) (Type, F	Print)	03488' 1 ill Driv	0-81117	0.5 800	ston Mi
-	te	31. Date filed (Month, Day Year), 3	32. Rapstrar's Sign	ature	uiw	CC 1011V	c succ	v cu.	71/2

			1 - State of Maryland / D	Department of Hea Certificate of De		ntal Hygie	ZIIIIh	41370
· ·	Physici /Medi		1. Decedent's Name (First, Middle, Last) Leonard L. McFado	den		Date of Death Month Dec. 7, 2	Day Year	3. Time of Death 3:30A M
	Examir		4a. Facility Name (If not institution, give street and number) National Lutheran Home	4b. City, Town, or Loc Rockv			4c. County of Deat Montgon	
l	Funeral Director				f Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Ye O'V • 5 , 1 9	9. Birt 2013 I C	hplace (State or Foreign untry)) W a
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Md. Montgomery 10c. City, Town	n or Location Rockville				10d. Inside City Limits Y☐ Yes 2☐ No
	h with the 23a or 28e	ai Director	10e. Street and Number 9701 - Veirs Drive	10f. Zip Code 20850	0	10g.	Citizen of What Co	buntry?
980	72 hours after death with the Maryland natural', or Items 23a or 28e-f show dical Evantinar must be rotified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Zwidowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1943-46	13. Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Specify Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	within ene. then "	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired) Mail Carries	ing most of working	16b	. Kind of Business/	Industry
Maryland ?		To Be C	17. Father's Name (First, Middle, Last) John McFadden	18.	Sarah			
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		Jean Smallin-Daughter 42	Mailing Address (Street and 221 – Willow	Wood Dr	.,Anna	ndale,V	a.22003
Baltimore,	9 - = =		1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Ma	Disposition (Name of y, crematory or other place) ary's cem.	12/15/		Moline	Town, State , Illinoia
Bal	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Dipensee	\perp 2222-Wisc	g Co.,Ir consin A	Ave., NW	,Wash.	
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on ach line. Immediate Cause (Final disease or condition resulting in death)	ony fai	V ~	espiratory arrest,		Approximate Interval Between Onlet and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	nia obstriction	e pulmer		a care	week
8760,	cate be executed oblysician and the burial-transit	dicai Exan	that initiated events resulting in death) Last c. Due to (or as a consequence of the co	nie	- Journal	very c	violate	week
.O. Box 6	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 DEctopic pregnancy 5 Other (specify)			23d. Date of deli	very Day Year
<u>α</u>	w requires that been signed b should be dett	by	Part II. Other significant conditions contributing to death out not resulting in	the underlying cause given in	n Part I.			the cause of death?
al Records,	The law ate has b page 2 s	Completed				24a. Was an autopsy performed'	prior to c death?	topsy findings available ompletion of cause of
Division of Vital	ding Phys n. After this funeral di	Certification; To Be	2 Accident investigation	patient 3 DOA Other: 4 ime of jury M 28c. Injury at Work? M 1 Yes	2 🗆 No	5 Residence Describe how in	jury occurred	
DIV	oltal or Ature durs after durs after dural Direct		4 Homicide determined 28e. Place of injury - At nome, far building, etc. (Specify)			City or Town, Sta	,	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Sig fature and title of certifier	death occurred at the time, d. Vor investigation, in my opinion 29c. License nur	on, death occurred a	it the time, date a	(s) and manner as and place, and due Date signed (Month	to the cause(s)
1	(3)		30. Name and address of person who completed cause of death (Item 23a) (1		726	De	cembe	7, 2006
	Sta	4.1	Dr. Charles Karesh- 9701-	Veirs Dr.,	Rockvi1	le,Md.	20850	
	Registr	ar	DEC 1 2 2006 Breen B. Goes					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 Month Year **Physician** Lamar Mason Dec. 15:18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cheverly Prince Georges Community Hosp. Prince Georges If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1/2 M 2□ F 67 Yrs. Director 247-66-6619 Mar.10,19395o. Carolina Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23a or 28a-f ehov the Medical Examiner must be mutified at 1 Yes 2 No Directo MD. Prince Georges Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7918 Roxbury Court 20785 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after Hygiene. ☐Yes 2☐No Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 No Specify: ð Specify: 3 ₩idowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Giant Food Store 12 Meat Cutter marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hitant: If itam 27 is marked oth Be Elizabeth Mosley William Mason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2434 Lenfant Square, S.E. Washington, D. C. 20020 19a. Informant's Name/Relationship (Type, Print) Theodolph Mason (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: If its
eny injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 12-13-06 Landover, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ralph Williams Funeral Service alph & Williams 1813 PotomacAve., SE; Wash., DC 20003 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Fatal Cardiac Arrythmia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed ettending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐ Onknown Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete hes birector, page 2 s autopsy performed? 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 XER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: **⊠**Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide • Funeral Medical 29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) .0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anita Clayton, MD 3001 Hospital Dr., Cheverly, MD. 20785 31. Date filed (Month, Day, Year) State DEC 0 8 2006 Registrar

Funeral Director

	1 - For State Registrar	State o		Certific	ate of	Death	т		Reg. No	ZUUb	4131
n al	Decedent's Name (First, Middle, I DIANNE	_{-ast)} PATRICIA	. MA	ARTIN				2. Date of De Month DECEMB	Da	y Year 5 2006	3. Time of Death 1:59 P
r	4a. Facility Name (If not institution, g PRINCE GEORGE'S			4b. (City, Town, or CHEVER		of Death		1	PRINCE O	
	5. Social Security Number 6 217-60-6811	Sex 1 □ M 2 ☒ F	7. Age (In yrs. last b	irthday) If U Yrs. Mon	nder 1 Year ths Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da JULY 2	th ly Year	9. Bir 951 WAS	thplace (State or Fore SHINGTON, DO
2	Usual Residence of Decedent 10a. State 10b. County MD PRINCE	GEORGE'S		wn or Location							10d. Inside City Lim
I Director	10e. Street and Number 617 BIRCHLEAF	AVENUE		101	Zip Code 20743				-	itizen of What C	ountry?
by runeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo	/8		ecedent of H specify Cuba es 2 No	lispanic Ori an, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ame Black, Whi	
Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 12th	Education grade completed) College (a. Decedent's (Give kind o life. DO NO	f work done of OT use retired	durina mosi	t of worki	ng		Kind of Business	/Industry
10 Be C	17. Father's Name (First, Middle, La SIDNEY PROCTOR	st)				18. Mothe		(First, Middle,	, Maider	n Surname)	
	19a. Informant's Name/Relationship BEVERLY MARTIN/I		19 1	b. Mailing Add	lress (Street LLE HA	and Numbe	or or Rura R #	1 Route Numb 202 LAI	er, City o NDOV	or Town, State, ER, MARY	Zip Code) LAND 20785
0	20a. Method of Disposition 1 🖾 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) RESURRECTION CEMETERY 12/11/2006 CLINTON, 1									INTON, MA	ARYLAND
	21. Signature of Funeral Service Lic	-lal								FUNEKAI MARYLANI	
	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on e	aused the death. Do each line. METASTATIO		-		cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	disease or condition resulting in death)	Due to	(or as a consequence	of):							
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	PTOMENINGE (or as a consequence	of):	.CINOMA	1					3.5
a a	resulting in death) Last	Due to	(or as a consequence	of);							
o									10		
ysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live t	tcome of pregnancy birth 2 Tetal death pant at time of death own		ic pregnancy r (specify)					23d. Date of de Month	livery Day Year
۵	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live t 4 ☐ Pregr 9 ☐ Unkn	ointh 2 ☐ Fetal death leant at time of death lown	5 🗆 Othe	r (specify)				obecco	Month	Day Year of the cause of death?
2	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live t 4 ☐ Pregr 9 ☐ Unkn	ointh 2 ☐ Fetal death leant at time of death lown	5 🗆 Othe	r (specify)			1 🗆 `	obecco Yes 2	Month use contribute to No 3 P 24b. Were an prior to death?	Day Year o the cause of death? robably 4 Unknow utopsy findings availat completion of cause of
o Be Completed by Physician/Media	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live t 4 ☐ Pregr 9 ☐ Unkn	inth 2 □Fetal death ant at time of death own eath but not resulting	5 ☐ Othe	r (specify)	en in Part I. 26. Place	of Death	24a. Was autor perfo	obecco Yes 2 an proprint of the correct of the corr	Month use contribute to No 3 P 24b. Were a prior to death? 1 Yes	Day Year o the cause of death? robably 4∭Unknov utopsy findings availate completion of cause of
Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital:	inth 2 Fetal death ant at time of death own eath but not resulting	5 ☐ Othe	ing cause give	en in Part I. 26. Place er: 4 □ Nu	of Death	24a. Was autor perfo	obecco Yes 2 an psy ormed? 2X No one) dence	Month use contribute to No 3 P. 24b. Were an prior to death? 1 Yes 6 Other (Spe	Day Year of the cause of death? robably 4\(\tilde{\tiiiitilee{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{

State Registrar

DHMH 17 Rev 1/2001

31. Date (iled (Month, Day, Year) DEC 0 8 2006

6124 LANDOVER ROAD CHEVERLY, MARYLAND 20785 PATRICIA EBEN M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0057636

DECEMBER 6 2006

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar	
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		•	1 - State Registrar		Cert	ificate of	Death		F	Reg. No.		
			Decedent's Name (First, Middle, Last)					2.	Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic		VIRGINIA I	MANLEY				I	EC		2006	630 PM
	Examin		4a. Facility Name (If not institution, give street and			4b. City, Town, o	or Location of D	Death		4c. Co	unty of Death	1
			HOWARD COUNTS GE	NERAL HOSP	inti	Celumb				+60	WARD	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 🔀	7. Age (In yrs. last bir	rthday)_ Yrs.	If Under 1 Year Months Days	Hours 1	Hrs. 8. Min. F	Date of Birth (Month, Day eD 24	r , 194	9. Birth	place (State or Foreign Tyland
and	A SI		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Loc	ation						10d. Inside City Limits
Mary	a-f eh	Director	Md Montgomery		Со	lumbia						Yes 2 No
th th	or 28	ire	10e. Street and Number			10f. Zip Code				10g. Citizer	of What Cou	ıntry?
X	238		7671 Wood Park La	ne #204		2104	5			U.	S.A.	
d E.E. 10-0000 filed within 72 hours after death with the Maryland	ral', or iteme 23a or 28a-f ehow Examinational be notified at	Funeral	1 Never Married 2 Married 1 Y	Decedent Ever in U.S. d Forces? es 2 No , Give		as Decedent of H Yes, specify Cub		? (Specifi Puerto Ric	y Yes or No- an, etc.)		Race - Amer Black, White ecify:	, etc.
	"natural", ndical Exe	d by	3 ☐ Widowed 42 ☐ Divorced Year	or Dates:	<u> </u>		opecny.			3,	Bl	ack
2	ntal Hygiene. ed other then "nature. event, the Wedles	Completed	15. Decedent's Education (Specify only highest grade complet	ed) 16a.	. Decede	ent's Usual Occup ind of work done O NOT use retire	pation during most of	f working		16b. Kind	of Business/li	ndustry
j j	hen Men	ם		ge (1-4or 5+)					.		3 5	3 0
1 2	tygie her t nt, in		12th Grade 17. Father's Name (First, Middle, Last)	AC	cou	nts Re	18. Mother's		irst Middle			rcel Ser.
- 0	_ 0 =	Be		G							,	
) lo	d Me nark natic	٦	Eldridge Wise 19a. Informant's Name/Relationship (Type Scient)		Mailing	Address (Street			nia_	Mil		in Code)
428	traur		Michele Manley	gnter)	-							#21113
ָר קַּ	Healt em 2 ther		20a. Method of Disposition			ition (Name of atory or other pla		Date			ion - City or T	
5	in it is		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr	Um State				2/1	6/06			
á	niun niun		4 Donation 5 Other (Specify) 21. Signature of Funeral Service (License)	поркт		Church		1	i _ l		- 1	
	Department of Health and Menta Importent: If Item 27 Ie marked any injury or other traumatic es		A Some D. July	uluila	S	Name and Address Nowden 46 N.	Funer	al l	Home	P.A.	2085	0 e, Md
			23a. Part1. Enter the disease, or complications th	at caused the death. Do								Approximate Interval Between
Ð	nysician		shock, or heart failure. List only one cause Immediate Cause (Final								1	Onset and Death
	Medical		disease or condition resulting in death) Due	to (or as a consequence	ANC of):	2						18 MONTH
E	xaminer											
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequence	of):							
cuted	ing physicien and e as the burial-transit	Examiner	Cause (Disease or injury that initiated events									
5 × 6	en ar irial-t		resulting in death) Last Due	to (or as a consequence	of):							
9 4	nysici he bu	icai	d									
	ng pl	Medicai	IF FEMALE:								<u> </u>	
DIVISION OF VITAL MCCOLOS, T. C. DOA 00100, 100 to the Hospite of Attending Physician: The law requires that the death cardificate he executed	within 24 hours after death. To the Funerei Director: After this certificete hes been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Physician/I	23b. Was decedent pregnant in the past 12 months?	, outcome of pregnancy ive birth 2 ☐ Fetal death regnant at time of death nknown		Ectopic pregnanc Other (specify) _	у			230	Date of deli- Month	very Day Year
thet	ned b deta		Part II. Other significant conditions contributing	to death but not resulting i	in the und	derlying cause gr	ven in Part I.		23e. Did to	obacco use	contribute to	the cause of death?
	n sign	Completed by	RENAL Failure, GI	· Bleed,	A	JAJARCI	4		1 🗆 Y	res 2001	lo 3□Pro	bably 4 Unknown
3 3	s bee	Jet	C. DiFF colitis,	معم ه لامسالا	Em	bolus			24a. Was	an 2	4b. Were aut	opsy findings available ompletion of cause of
r ad	age 2	E						_	autop perfor 1 Yes	rmed?	death?	2 No
	tifice for, p	0	25. Was case referred to medical				26. Place of	Death (C		ne)	100	2010
Vaici V	is cer direc	To B	examiner? 1 ☐ Yes 2 No Hospital:	Inpatient 2☐ ER/Ou	utpatient	3□ DOA Ot	nar				Other (Spec	nfy)
5 5	er thi		27. Manner of Death 28a. D	ate of Injury 28b.	Time of Injury	28c. Inju Wo			I. Describe h			,,
5 8	ath. Fr: Ath	atio	2 Accident investigation	norm, buy , our	,u.y		Yes 2□No					
	s after de li Directo id in by th	Certification:	3 Suicide 6 Could not be 28e. P 4 Homicide determined b	lace of Injury - At home, fa uilding, etc. (Specify)	arm, stre	et, factory, office		28f	Location (S City or Tou		lumber or Rui	ral Route Number,
e Hospit	24 hour	Medical (29a. Certifier (Check only one) Certifying Physician: To Medical Examiner: On the and of									
Toth	withir To th comp	Me	29b. Signature and title of certifier			29c. Licen	se number			29d. Date s	igned (Month	, Day, Year)
	3		1 hm	~ MD	•		469					2006
			30. Name and address of person who competed	cause of death (Item 23a)	(Type, P							
			JEREMO YOSPIN	5755	CE	DAL L	ANE		elum	DIA	アツ	

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

5:35 A

Montgomery

Birthplace (State or Foreign Country)

White

USA

10d. Inside City Limits

1 X Yes 2 ☐ No

	2	Home Maker		Own Ho	ome
17. Father's Name (First, Middle, Las	t)		other's Name (First, Middle, M	,	
Morris Dachman		Sop	hie Greenspun	<u>.</u>	
19a. Informant's Name/Relationship Jack Mehlman/Husba		19b. Mailing Address (Street and Num 918 Clintwood Dri	nber or Rural Route Number, .ve, Silver Sp	City or Town, State, 2	Zip Code) 71and 20902
20a. Method of Disposition 1X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Speci	Removal from State	Place of Disposition (Name of Lemetery, crematory or other place) TZ HACHAIM CEMETER		20c. Location - City or	
21. Signature of Funeral Service Lice		22. Name and Address of Fa	cility FUNERAL DIRECT	TION, INC.	IAND 20852
23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused the ceat	h. Do not enter the mode of dying, such			Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)		SES (BILATERAL)			Onset and Death MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. RENAL CELL C	ANCER			YEARS
Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or as a consequent)	uence of):			·
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 Ectopic pregnancy		23d. Date of del Month	ivery Day Year
Part II. Other significant conditions of DIABETES MELLITUS		ulting in the underlying cause given in Pa	rt I. 23e. Did toba	acco use contribute to s 2 🙀 No 3 🗆 Pr	the cause of death?
CORONARY ARTERY D	ISEASE		24a. Was an autopsy		topsy findings available completion of cause of
ACUTE RENAL FAILU	RE		perform	ed? death? L No 1 ☐ Yes	
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatient 2 □	Othori	ace of Death (Check only one,		oih)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury at Work? M 1 ☐ Yes 2	28d. Describe how		ony)
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of injury - At ho building, etc. (Specify	me, farm, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
29a. Certifier (Check only one) 1X Certifying Pl 2 Medical Example 1	nysician: To the best of my knominer: On the basis of examina and manner stated.	wledge, death occurred at the time, date tion and/or investigation, in my opinion, o	and place, and due to the cau leath occurred at the time, dal	use(s) and manner as te and place, and due	stated. to the cause(s)
29b. Signature and title of certifier WWW arm	F. Smion	29c. License number D3652		d. Date signed (Month	
30. Name and address of person who	completed cause of death (Item				
B1. Date filed (Month, Day, Year) DEC 11 200	22 Registrar's Signa				,
		ORIGINAL			

State Registrar

10

				State of Man				•	9	•
		1	1 - For State Registrar			rtificate of			eg. No. 006	41375
	Physici		1. Decedent's Name (First, Middle, La	ist)				2. Date of Deal	th Day Yea	3. Time of Death
	/Medic		Carl R. Mauzy					12	15 200	06 10:50 A ^M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Dea	th	4c. County of De	
		*	Frostburg Villa 5. Social Security Number 6.5		Home n yrs. last birthday)	+	stburg	8. Date of Birth		legany
62.	Funeral Director			19 M 2□F 7		Months Days				Birthplece (State or Foreign Country) aryland
	*		Usual Residence of Decedent					102/12/1	1954 110	II y Land
	urylan show	_	10a. State 10b. County		Dc. City, Town or Lo					10d. Inside City Limits
	889-f	Director	MD Allega	ny		Cumberla	.nd			1¼ Yes 2 □ No
	with th		10e. Street and Number	0.04		10f. Zip Code	21502	1	Og. Citizen of What USA	Country?
	y within 72 hours after death with the Maryland liene. r then "neturel", or teme 23a or 28e-f show the Medical Examinar must be incitied at	Funeral	214 Cumberland	12. Was Decedent Eve	r in U.S. 13	Was Decedent of h		Specify Yes or No-		merican Indian,
(0	ritter d	Ē	1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	Korean			Specify Yes or No- to Rican, etc.)	Black, Wi	
036	el', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: Wa		1 ☐ Yes 2 📉 No	Specify:		Specify:	White
21215-0036	72 hc netur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup kind of work done	during most of wo	rking	16b. Kind of Busines	ss/industry
121	within ene. then "	d m	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	od)		a ,	
	D 0 =		12 17. Father's Name (First, Middle, Last)		Truck Dr	T	me (First, Middle, I	Contra	actor
an	a a b y	To Be		Mallow	Mau	ZV	Edith			pitznas
Maryland	s 1 and 2 should be file. I Health and Mental Hyg Item 27 is marked othe other treumatic event.	F	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Number	, City or Town, State	, Zip Code)
Ž	5 = 2 t		Ruby E. Mauzy /	wife	214	Cumberla	and Stree	et, Cumber	rland, MD	21502
ore,	permit. Pages 1 a Department of Hea Important: If item any njury or othe once		20a. Method of Disposition 1 🔀 Burial 2 🗍 Cremation 3	1	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ice)	Date	20c. Location - City	or Town, State
Baltimore	it. Pages nument of l ntant: If it njury or o		4 □ Donation 5 □ Other (Speci		ID Vet. C	em @ Rock	cy Gap 12	2/19/2006	Flints	tone, MD
3alt	permit. Departm Imports any nju		21. Signature of Funeral Service Lice	nsee		2. Name and Addre			-	al Home, P.A.
_	0.0 ⊆ 6 d		Labert C	allans					rland, MD	
-			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each line.		ter the mode of dy	ng, such as cardia	c or respiratory arm	est,	Approximate Interval Between Onset and Death
1	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a	estive	hea	rt F	endur	<u>e</u>	I TWO WEEK
	Examiner			Due to (or as a d	onsequence of):	andi A	modet	. H J		1 years
	T. MAK	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	onsequence of):		0	Mul		
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o vo na	ry c	entary	Disc	rel	30 years
760,	sicien and burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):	U	0			
6876	The law requires that the death certificate be executed tite has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	dlcal	•	d						
	death certificate b attending physi of for use as the b	Physiclan/Medl	IF FEMALE:	23c. If yes, outcome of p	regnancy				001 0-1-1	1.0
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at tim	Fetel death 3	Ectopic pregnanc	у		23d. Date of d Month	Day Year
P.O.	that the de red by the a detached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown						
	es thai igned t	by P	Part II. Other significant conditions	contributing to death but n	ot resulting in the u			23e. Did tob	pacco use contribute	to the cause of death?
rd	w require been sig should b	ted	Sepsis,	COP	17- (Diabete	2	1)X(Ye	as 2□No 31□	Probably 4 Unknown
of Vital Records,	as be	Completed	melle	tis. Per	pheral	onter	ial	24a. Was a autops		autopsy findings available to completion of cause of
<u>=</u>		Con	Di	seene	V			perform 1 Tes 2	ned? death'	? es 2□No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		104		ath Check only on		
o	d is	. To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatier	IL 3 DOA			ence 6 Other (Spow injury occurred	pecify)
	ding h. After fune	to	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ear) Injury	Wo	rk?]Yes 2 □ No	200. Describe no	ow injury occurred	
Division	Atten r dea ector	flca	3 Suicide 6 Could not b	28e. Place of Injury	- At home, farm, st			28f. Location (St	reet and Number or	Rural Route Number,
Ö	s afte	Certification:	4 Homicide	building, etc. (Specity)			City or Town	n, State)	
	To the Hospitel or Attending Pr within 24 hours atter death. To the Funeral Director: Atter th completely filled in by the funeral		29a. Certifier 1 Certifying P	hysician: To the best of m miner: On the basis of ex	ny knowledge, deat	h occurred at the til	me, date and place	e, and due to the ca	ause(s) and manner	as stated.
	the P the P the P	Medical	one)	and manner stated	l					
	To To Cor	~	29b. Signature and title of certifier	5/ Jan	dhin Hi	29c. Licens	se number	4	9d. Date signed (Mo	ntn, Day, Year)
,	3/10A		00 November 1		- ()	7	10/18/	2006
	nes		30. Name and address of person who Sikander L. S	•			e Enact	burg, MD	21532	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's		in terrac	e, Frost	ourg, Pin	۲۱۷۵۲	
	Registr		DEC 1820	Jub 3000	S. Co	CARL!				

	5 y		1 - For State Registrar 1. Decedent's Name (First, Middle, Las	State of Ma	rylan				ealth a Death	and M	ental Hy	Reg. No	とせせら	3. Tim	376
	Physic /Medi Exami	cal	Clifford 4a. Facility Name (If not institution, give	Lest	ter	M	c Coy	Town, or	Location o	f Death	Month Decem	Da ber	11, 20	06 8:	05 P M
S.	Funeral	lei	14700 Ruby Ros 5. Social Security Number 6. So	ad 7. Age		as <i>t birthday)</i> Yrs.			dtowr If Under a	1	8. Date of Bir (Month, Da 02/12)		Allega	any rthplace (Sta	te or Foreign
e la	Director		Usual Residence of Decedent 10a. State 10b. County	. 9		r, Town or Lo					02/12/	/191	3 Mar		e City Limits
	with the Ma la or 28a-fa	Funeral Director	MD Alleg			0	ldtow 10f. Zip	Code	 555			10g. Cit	tizen of What C		∕es 2∭No
036	filed within 72 hours after deeth with the Maryland Hygiane. other than "natural", or iteme 23a or 28a-f show ent, the Madical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? 1 Tyes 2 Tho If Yes, Give Year or Dates:		1	Vas Deced Yes, spe-	dent of His cify Cubar		gin? (Spe , Puerto I	ocify Yes or No Rican, etc.))-	14. Race - Am Black, Wh		1,
21215-0036	d within 72 ho piene. r than "natura the Medical i	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 8		-)	16a. Deced (Give life. L	lent's Usua kind of wo DO NOT us Labo	rk done d se retired)	uring most	of works	ng		ind of Busines	s/industry	
	hould be filed d Mental Hyg marked othe matic event,	To Be C	17. Father's Name (First, Middle, Last) Albert 19a. Informant's Name/Relationship (7	M.		McCoy	a Address		E1:	izabe				rphy	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-f show empty injury or other traumatic event, the Madical Examiner must be nutified at ODGs.		Minnie A. Dibert 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Fundantial Service Licen	/ sister Removal from State	1	220 So ace of Dispo- emetery, crem berlar	omerv sition (Nar natory or o id Cre . Name ar	rille me of other place emato ad Addres	Aven	2/13 Ada	Apt. 4 ate /2006	10, 20c. Lo Cur	Cumberlocation - City on the City of the C	and, Town, State	, P.A.
8760,	Physician //Medical Examiner physicieu and	ilcal Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (or as a c. Due to (or as a d	consequ	rence of):	er the mod	le of dying	, such as	D N	r respiratory a	rrest,			nate Between nd Death
P.O. Box 6	ath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal	death 3	Ectopic pr Other (sp						23d. Date of de Month	olivery Day	Year
	w requires that the de been signed by the e should be detached t	þ	Part II. Other significant conditions co	entributing to death but	not resu	lting in the un	derlying c	ause give	n in Part I.		10	Yes 2	_	robably 4	□Unknown
Vital Records,		Be Completed	25. Was case referred to medical						26. Place	of Death	24a. Was autop perfo 1 Yes	osy ormed? 2 12 No	death?	utopsy findin completion o	gs available of cause of
Division of V	ding Phy .r After this funeral d	Certification: To E	examiner? 1 Yes 2 No 27. Manne Death 1 atural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide	1 _ Inpatient 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	Year) y - At hor	ER/Outpatient 28b. Time of Injury me, larm, stre	M 2	8c. Injury Work	r. 4 □ Nur	sing Hom 2	ne 5 Resid 8d. Describe	dence how injur	d Number or R		lumber,
_	Hospitei 4 hours a Funerei I	edical	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exam	vsician: To the best of iner: On the basis of e and manner state	xamınati	vledge, death ion and/or inv	occurred estigation,	at the time	e, date and inion, deat	place, a	nd due to the	cause(s) date and	and manner a d place, and du	s stated. e to the caus	Θ(S)
	3	W	29b. Signature and title of certified 30. Name and add so of some who co	Cagov omplet a se of dea	Ath (Item	23a) (Type, F		: License D2218					te signed (Mon Cember		
	Sta Registr		Gary L. Wagon 31. Date filed (Month, Day, Year) DEC 1 2 200	324 Aegistrar		nte .	p Wa	lsh I	Drive	, Cui	mberlar	nd, I	MD 215	02	

			For State Registrar	State of Marylan		artment of F			giene	0.06	- Comment	377
			1. Decedent's Name (First, Middle, Last))				2. Date of Dea	ath	, , ,	3. Time o	f Death
	Physic /Medi		William Richar	d Myers				Dec	09	2006	211	O M
i.	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Dea			ty of Death		-
			Carroll Hospit	al Center		Mes	tminste	r	Ca	rroll		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birt	h		ace (State o	or Foreign
	Director		220-03-0997	My 2□F 87	Yrs.	World S Days	Tiodis Will	Sept		Count		MD
	and *		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	cation			-	10	Nd 114- 0	24 1 tit-
	Aaryli sho	5								10)d. Inside C	2 □ No
	28a-1	ect	10e. Street and Number	rroll	wes	tminste:	r		40.000			2 110
	with with	ā	463 East Green	Stroot		10f. Zip Code	21157		10g. Citizen of		ry?	
	ne 23	Funeral Director		12. Was Decedent Ever in U.	S 13 V		21157	Spanifu Van ar Na		USA	no lodice	
	ter d	Ξ	1 Never Married 2 Married	Armed Forces? 1	1 1	Was Decedent of H. f Yes, specify Cuba	in, Mexican, Puer	to Rican, etc.)	BI.	ace - America ack, White, e		
93	urs a	þ	3 √Widowed 4 □Divorced	If Yes, Give Year or Dates:	' ' '	I□Yes 2□XNo	Specify:		Spec	ify: Wh	ite	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiane. Id other then "natural", or iteme 23a or 28a-f show event, the Madical Examinar must be rediffed at	Completed	15. Decedent's Educ	cation	16a. Deced	lent's Usual Occup	ation		16b. Kind of I	Business/Ind	ustry	
7	within 7 ane. then "r	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done o OO NOT use retired	during most of wo f)	rking	Co Ow	ner	•	_
2	filed with Hygiane. Ither ther	Son		2		Meat Pa	acker		Wm F.	Myer	s &	Sons
nd	tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Suma	ame)		
<u>X</u>	should by	2	Oliver L. Myes	rs			Mar	y Loque				
Maryland	0.00 = =		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailin	g Address (Street a	and Number or R	ural Route Numbe	r, City or Town	n, State, Zip (Code)	
2,	s 1 and 2 f Health item 27 other tre		Carol Kelly/ste		6	19 Woods	side Dr	v West	minst	er, M	D 2	1157
altimore,	of of a		20a. Method of Disposition 1X Burial 2 Cremation 3 R	emoval from State	lace of Disposementers	sition (Name of natory or other place	e) 12/	13°/2006	20c. Location	- City or Tow	n, State	
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Ball	pernit. Pag Department Important: I any njury o		21 Signature of Funeral Service License	7	$\mathbf{P}_{\mathbf{I}}^{22}$	Name and Address	s of Facility	Home an	d Cha	pel.	P.A.	
_	405 g d		July HA		4	12 Washi	inaton	Road W	estmi	nster	. MD	211
			23a. Par 1. Enter the disease, or compli mock, or heart failure. List only on	cations that caused the death re cause on each line.	n. Do not ente	er the mode of dying	g, such as cardia	c or respiratory are	est,		Approximate Interval Bet	е
	Physician		Immediate Cause (Final disease or condition	VENTRICL	LAR	FIRRI	LLATIC	N.1		6	Onset and [Death
1	/Medical Examiner		resulting in death)	VENTRICU							10- 811	O(11)
4	Examiner		Sequentially list conditions.	ATHEROSCLE	ROTIC	HEART	DISE	ASE		1	o ye	ans
	D 15	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):							
	and tran	cam	that initiated events resulting in death) Last									
8760,	cate be executed bhysician and the burial-transit		1	Due to (or as a consequ	ience of):							
87	physi the I	dicai	d									· · · · · · · · · · · · · · · · · · ·
9 ×	death certifical e ettending phy of for use as th	Physician/Med	IF FEMALE:	20 11 1100 0 1100 0 1								
Вох	eath o	an	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3 🗌	Ectopic pregnancy				ate of delivery		/ear
P.O.	the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5∐	Other (specify)				01111	ay i	oai
	that the death led by the etter detached for u		Part II. Other significant conditions con	tributing to death but not resu	ulting in the un	derhing source awa	on in Part I	220 Did to	haass uss see	at all to the state of		
Division of Vital Records,	9 <u>5</u> 8	d b	•	and an additional action to action t	inting in the dif	donying cause give	miniratti.	1 U Y	bacco use con es 2 NVo	3 ☐ Probat		
Ö	w requir been s should	Completed							93 2 EQ/140		JIY 4 ∐U	nknown
3e	elaw hasi ya 2 s	Id I						24a. Was a autops	y /	Were autops prior to comp	y findings a	available ause of
a	i: The icate h							perform 1 ☐ Yes		death? 1 ☐ Yes 2	□ No	
Ž.	Attending Physician: If death. Sector: After this certific by the funeral director.	Be	25. Was case referred to medical examiner?	ospital:		la		ath Check only on	е)			
o	Phys this aldir	5	1 ☐ Yes 2 ☐ Mo	1 Mnpatient 2 ∐ I	ER/Outpatient		4 LI Nursing F	lome 5 Reside				
Ę	After funer	6	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho	ow injury occur	rred		
i <u>s</u> i	death death stor:	Cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	20 - Black of Injury At 1			/es 2 □No					
Š	or A after Direct in by	Certification;	4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, rarm, stre)	et, factory, office		28f. Location (St City or Town	reet and Numi n, State)	ber or Rural I	Route Numb	⊅er,
	Hospital 24 hours Funeral tely filled		29a. Certifier 19 Certifying Physi	ician: To the best of my keep	uladga daath							
	PFur etely	Medical	(Check only 2 Medical Examin	ician: To the best of my knower: On the basis of examinat and manner stated.	ion and/or inve	estigation, in my op	e, date and place inion, death occu	red at the time, d	ause(s) and m ate and place,	anner as stat and due to the	ed. 1e cause(s)	,
	To the Pospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate he completely filled in by the funeral director, paga	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signe	ed (Month De	IV. Yearl	
	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	4	Chilippleder	Neigama		D0018		-	_	2/06	,, · • • • • · •	
7	MJr	}	30. Name and address of person who cor	noleted cause of doors (II	23a) /Trees 5				100,110			
	10			AGANNA MD.	1100-A	pode Ro	(COLECT	MINSTE	RMT	911	57	
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signat		porte no	ا دعالت ا	1 1(14)	- 10	, 511	- ,	
	Registr		DFC 1 2 21		16 1	Coast 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2006 Townsend Graham Motlev December 5:55 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Anne Arundel Medical Center</u> <u>Annapolis</u> Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 ☐ F Director 88 09/04/1918 South Carolina 250-10-3935 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 801 Midship Court 21401 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 K Yes 2 □ No If Yes, Give Year or Dates: 1 1 Never Married 2K Married 1 ☐ Yes 2X No Specify ð Specify: 3 ☐ Widowed 4 ☐ Divorced 1944-46 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the 12 Meat Cutter Grocery permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Cleveland Anderson Motley Susan Graham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Midship Court, Annapolis, Mary K. Motley/Wife Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 12/11/2006 Crownsville, Maryland 21. Signature 115 mg/s Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Ull 100 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumo uch **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Valvulor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dise to (or as a consequence of). burial-transit Due to (or as a consequence of): attending physician Physician/Medical as the t IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Month Year 5 ☐ Other (specify) Tyes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy certificate 2∏No 1□ Yes 2**/2** No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Natural 2 ☐ Accident (Month, Day Year) 5 Pending investigation nours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed or Attending Physician: To the Hospital o within 24 hours aff To the Funeral D

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEC 0

obert

Registrar DHMH 17 Rev 1/2001 MI

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pe terson

8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month December 6, 2006 10:17 A M Bruce Wayne Masciarelli 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Hours 214-52-9257 03/25/1956 50 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 1 ☐ Yes 2X No Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2829 Fennel Road 21037 United States 12. Was Decedent Ever in U.S. Armed Forces? 1⊈TYes 2□No If Yes, Give Year or Dates: 1974–76 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 □ Never Married 2 ▼ Married 1 ☐ Yes 2X No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Insurance Agent Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace A. Robb Joseph G. Masciarelli 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol A. Masciarelli/Wife 2829 Fennel Rd., Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial Gardens 12/09/2006 Davidsonville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur I pund I pervice Dicensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ulmonor Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

"natural", or Items 23a or 28a-f shovidical Examiner must be notified at

the Medical

and Mental Hygiene. Is marked other than

permit. Pages 1 and 2: Department of Health ar Important; If Item 27 Is

injury o

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division or Vital Records,

as use page

Examine physician and s the burial-trans Physician/Medical the signed by t þ has been sig Completed certificate Be this o P After this funeral of

IF FEMALE: 25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

(Check only one)

State Registrar

the death certificate be executed or Attending Physician: Certification: within 24 hours after death.

To the Funeral Director: / To the Hospital Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier lease

Hospital:

1 Inpatient

(Month, Day Year)

28a. Date of Injury

D24804

Other:

1 Yes

2∏No

28c. Injury at Work?

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

AMC Annagely MD 21401

29d. Date signed (Month, Day, Year) 12-6-06

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, DEC 0 8 2006

ober

2 📉

5 ☐ Pending investigation

6 ☐ Could not be

determined

erson MI 32 Registrar's Signature

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

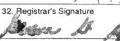
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Ragistra Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MOORE **Physician** GILBERT 0300 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10 M 2□F Months Days Hours Min 243-22-7337 Yrs. 84 Director July 23, 1922 New Jersey Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ma 23a or 28a-f ehow must be notified at Maryland Anne Arundel Annapolis Completed by Funeral Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1301 River Crescent Drive 21401 U.S.A. ! Itama! 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: ₩₩ II 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. other traumatic event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural; or ite aury or other traumatic event, the Madical Examinary or other traumatic event, the Madical Examinary. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer 5+ Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gilbert H. Moore Lois Phillips 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Moore/wife 1301 River Crescent Drive Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If ony injury or Baltimore Crematory 12/8/2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signatural Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Honknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? SINO 2□ No 1 ☐ Yes 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 100 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of cortifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DEU 0 8 ZUUD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		partment of Health and Mental Hy ertificate of Death	
Physician		2. Date of E Month DECEMB	Death 3. Time of Death
/Medical Examiner	4- 5-29 11 17	4b. City, Town, or Location of Death LA PLATA	4c. County of Death CHARLES
Funeral Director	5. Social Security Number 6. Sex 1 M XXF 7. Age (In yrs. last birthday Yrs.	Months Days Hours Min. (Month, D	
ryland	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show rights be notified at	MARYLAND CHARLES WALI 10e. Street and Number	DORF 10f. Zip Code	1 ☐ Yes 2 🙀 No
ath w	70 VILLAGE STREET	20601	U.S.A.
036 urs atter	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes Yes Yes X Yes X Yes	14. Race - American Indian, Black, White, etc. Specify: WHITE
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Maryland Maryland d 2 should be file that and Mental by ty 1s marked oth traumatic even	NICHOLAS FIEDLER	18. Mother's Name (First, Middle MARY HILDEE	BRANDT
Mar and 2 sh satth and n 27 is m	1	ling Address (Street and Number or Rural Route Num PEARL ST. WHITE PLAI	
Baltimore permit Pages 1: Department of He importent: If item	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		20c. Location - City or Town, State
Batti Permit Departir Importe any inlu	21. Signature of Funeral Service Licensee MOO/179	22. Name and Address of Facility RAYMOND FUNERAL SERVI LA PLATA, MD. 20646	
Physician // Medical Examiner e bural-transit e bural-transit cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Suquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		Approximate finterval Between Onset and Death
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Division of To the Hospital or Attending Profits 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to the avestigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. , date and place, and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
\$	30. him and address if person who completed cause of death (Item 23a) (Type	D. WARDORY- N	11 20603
State Registrar	31. Date filed (Month, Day, Year) SEC 2 7 2006 32. Registrar's Signature	parts!	

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			for State	State of Ma	aryland /				Mental Hy	/gien	2006	41382
			Registrar 1. Decedent's Name (First, Middle, Last)			Certifica	ale or i	Dealli	2. Date of D	Reg. No	5.	3. Time of Death
	Physici /Medi		Anna Gertrude	Marshall					Month	Da	8 200	r
	Examir		4a. Facility Name (If not institution, give s	. 11	1	4b. Ci	ity, Town, o	r Location of Dea	th	_	. County of De	l.
			5. Social Security Number 6. Sex		OSD I TO	introduci If Und	der 1 Year	If Under 24 Hrs	9 Date of B	1	Dorche	
	Funeral Director		215-18-4734	M 200 F	85 	Yrs. Month		Hours Min		3, 1	921 Ma	irthplace (State or Foreign Country) aryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Location						10d. Inside City Limits
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3	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Items 23a or 28a-f show or other treumatic event, Ite Maylical Exam	Completed by Funeral Director	10e. Street and Number 1005 Hudson Rd.			10f. i	Zip Code 2	1613		10g. C	itizen of What o	Country? SA
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336	urs after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ ↑ If Yes, Give Year or Dates:	No		2046	Specify:	to rilouit, sto.)			Mite √hite
2-0	72 hou	ted	15. Decedent's Educ (Specify only highest grade		16a	Decedent's U:	sual Occup	ation during most of wo	rking	16b. F	Kind of Busines	s/Industry
21	ithln e. ner	npie	Elementary/Secondary (0-12)	College (1-4or 5	i+)			during most or wo	rking		D	
2	iled w dygier ther ti nt, th	S	17. Father's Name (First, Middle, Last)			Cle	rĸ	19 Matharia Na	me (First, Middle	Majda	Retail	L
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Box 68	certifi nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome	of pregnancy			·			23d. Date of d	elivery
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			30. Name and address of person who cor	Impered cause of de	eath (Item 23a)	(Type, Print)	Bul	n 5+	Can	ahr	die	11021612
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	/Medio Examin		4a. Fecility Name (If not institution, giv				4b. City, T	Town, of	Location		200020		ounty of Death	1 0000 2
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	Funeral		Social Security Number 6. 8		e (In yrs. la		If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birthr	olace (State or Foreign ntry)
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	and	}	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						1	10d. Inside City Limits
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36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🕅 f If Yes, Give Year or Dates:	No		1 ☐ Yes 2						pecify: B1	Lack
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obera	ospital of hours at uneral D		20 Oction 4 M Continue I	Physician: To the best	of my kno	wlodgo deal	th occurred	at the tir	me date a	nd place :	and due to the	ause(s)	and manner as	stated
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	- st 0	-	I I Va	UX			I	0629	49			Dece	mber 7,	2006
_	5		30. Name and address of person wh	o complete cause of	death (Item	23a) (Type	, Print)						7	
			Natasha Haag, M.					oad,	Beth	nesda	, MD 20	814		
		ate	31. Date filed (Month, Day, Year) DEC 1 1 2	2. Regist	trar's Signa	ture	des							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 8:05pm 13,2006 December Robert Dillon O'Boyle, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Director 188-14-0769 03/24/1921 PAUsual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at MD Washington 1 ☐ Yes 2 No Hagerstown Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20014 Rosebank Way #227 21742 US or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No White Specify: Completed by 3∑ Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 Is marked other the any injury or other traumatic event, the angles. Supervisor Truck Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Francis O'Boyle Margaret Catherine Dillon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter W. O'Boyle / Son 12902 The Terrace, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) St.Catherines Cemet. 12/19/2006 Moscow, PA 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Ligensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Du to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

pulmonary	Jelevosis			1 □ Y	es 2□	No 3 Probably Unknown
				24a. Was a autop perfor 1 ☐ Yes	sy med?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No
25. Was case referred to medical			26. Place of De	ath (Check only or	ne) [°]	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐ D	OA Other: 4 Nursing	Home 5 ☐ Resid	ence 6	□Other (Specify)
27. Manner of Death 1		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe h	ow injury	occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			ry, office	28f. Location (S City or Tow	treet and n, State)	Number or Rural Route Number,
	hysician: To the best of my kniner: On the basis of examinand manner stated.					
29b. Signature and title of certifier	7	29	Oc. License number	2	29d. Date	signed (Month, Day, Year)

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

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	end 162 15/2006		riedse i	ype or Print in State of Maryla				-	_	
			1 - For State Registrar	Otato of Maryta		tificate of			Reg. No. 2001	5 4/385
			Decedent's Name (First, Middle, Last)					2 Date of Dea	ath	3. Time of Death
	Physici		Craig Waer Penn	over				Decemb	$ m er^{Day}$, 2006	10:40 AM
1	/Medio Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or	r Location of Dea		4c. County of Dea	
	LAGIIII		3001 Brock Drive			Upper M	arlboro		Prince G	eorge's Co.
	Funeral		Social Security Number 6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h 9. Bi	rthplace (State or Foreign
	Director		212-78-0236	M ^{2□ F} 47	Yrs.	Wortins Days	riours will	Nov. 19	, 1959 Was	shington, DC
	p .		Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Lo	cation				10d. Inside City Limits
	aryta ehov	5			only, Town of Lo	cation				1 ☐ Yes 2 X No
	Ne M	Director	MD Prince Ge	orge's I	Jpper Ma				10 000 - (140 -)	
	be filed within 72 hours after death with the Maryland hat Hygiene. Ind Hygiene and the first file we say or 28a-f show other than "natural", or iteme 23a or 28a-f show event, the Medical Examinar must be notified at	늅	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	• 23	Funeral	3001 Brock Drive	2. Was Decedent Ever in	11.6 12.1	20772	inneria Origina //	Coost Vacantia	U.S.A.	ocion Indian
	item item	nu.	11. Marital Status 1 ☒ Never Married 2 ☐ Married	Armed Forces?	0.5.	Was Decedent of H f Yes, specify Cuba	in, Mexican, Pue	rto Rican, etc.)	Black, Wh	
5-0036	rs aff		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2☒No	Specify:		Specify: W	hite
ŏ	2 hou	Completed by	15. Decedent's Educ	ation		tent's Usual Occup			16b. Kind of Busines	s/Industry
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2121	d within giene. r than	E	12	College (14401 34)	Fire	- Fighter				ire Departme
ק	e filed Il Hygi other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
<u>a</u>	Mental	TO	William F. Penno	yer			Doroth	ny E. Wae	er	
Maryland	s 1 and 2 should be filed with fleath and Mental Hygiene flem 27 ie marked other tha other traumatic event, Lie		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street	and Number or F	lural Route Numbe	er, City or Town, State,	Zip Code)
	5 ₹ Z = Z		William F. Pennov	er (Father	3001	Brock Dr	ive. Upr	or Marlb	oro, MD 20	772
ore	m O		20a. Method of Disposition	20b	. Place of Dispo	sition (Name of natory or other place	em. Dec	Date 12,	20c. Location - City o	r Town, State
Ĕ	nit. Page artment o ortant: if injury or		1 X Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)		rinity I	Episcopal	Ch.	2006	Upper Marl	
Baltimore,	permit. Page Department Important: if eny injury or		21. Signature of Sanoral Service License						1 Home Cal	
	Physician /Medical Examiner		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cods	equence of):	Cell Canc	inoma of	Left Lui	g stage The	Interval Between Onset and Death Menths
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ecords, P.	The law requires that the site has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute es 2 No 3 P	to the cause of death? Probably 4 Unknown
~		Completed						24a. Was autop perfor 1 □ Yes	sy / prior to	
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				eath (Check only o		
ō	d S	၉	1 Yes 2 No	1 ☐ Inpatient 2 28a. Date of Injury	☐ ER/Outpatien 28b. Time of		4 🗀 Ivuising		lence 6 Other (Spenow injury occurred	ecify)
		o	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	yat k? Yes 2 ∐No	Zod. Describe in	low injury occurred	
Division	if or Attending after death. Director: Aftar I in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)			28f. Location (S City or Tow	Street and Number or F n, State)	Rural Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my k ler: On the basis of exami and manner stated.	nowledge, death	occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the curred at the time, c	cause(s) and manner a date and place, and du	is stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	0		29c. Licens		:	29d. Date signed (Mon	/
			lan you	yling 48		<u>J</u>	14730		1-/11/	1006
	_		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type,	Print)				

15

State Registrar Kai-Yiu Yeung, M.D. 8926 Woodyard Rd., Suite 201, Clinton, Maryland 20735

31. Date filed (Month, Day, Year)

DEC 1 2 2006

	1	For State Registrar	State of M	/larylan		artment of H		ind Mental I	Hygier	2000	41386
	_	1. Decedent's Name (First, Middle, L	ast)					2. Date o		ay Year	3. Time of Death
Physicia /Medica	_	Erma M. Pi	ophet					DEC	12	2006	12.30AM
Examine	_	4a. Facility Name (If not institution, g	ive street and numbe	r)		4b. City, Town, or	r Location o	f Death		c. County of Death	
		Holy Cross Rehab				Burton				Montgome	
Funeral			Sex 7.7		- Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month	, Day, Yea		place (State or Foreign ntry)
Director		180-18-8571 Usual Residence of Decedent	X	8)			Aug	4,	1921 Pen	nsylvania
yland		10a. State 10b. County		10c. City	y, Town or Lo	cation					Od. Inside City Limits
a-fel	בַּלַ	Florida Saraso	ota	Ve	enice						Y☐Yes 2☐No
in the contract of the contrac	Director	10e. Street and Number				10f. Zip Code	000		10g. (Citizen of What Cou	•
ath w	<u>a</u>	166 Golf Club La					293			U. S.	
ING 21215-0036 be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or Items 23s or 28s-f show event, the Madical Evanther must be notified at	by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	2 4 No		Was Decedent of H f Yes, specify Cuba I □ Yes 2 No	lispanic Orig an, Mexican Specify:	jin? (Specify Yes o , Puerto Rican, etc.	r No-)	14. Race - Ameri Black, White, Specify: W	
2 Po	Completed	15. Decedent's (Specify only highest g			16a. Deced	lent's Usual Occup	ation	of working	16b.	Kind of Business/In	dustry
thin 7	n pe	Elementary/Secondary (0-12) 12 Years	College (1-4o	r 5+)	life. I	DO NOT use retired	1)	· ·			
d 27					Off	ice Super				nsurance	Company
Z Z z z z z	o Re	17. Father's Name (First, Middle, Las George Euler	51)					rs Name (First, Mic Mamie (Ur		n Sumame) rtainable)
Nore, Maryls ges 1 and 2 should at of Health and Mer if item 27 is mark or other treumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address (Street	a <i>nd Nu</i> m <i>b</i> e	r or Rural Route Ni	ımber, City	or Town, State, Zip	Code)
Te, M 1 and 2 Health tem 27 i	-	Beverly A. Prop	het-Daugh				d Roa	d, Ashtor			0861
Pages 1 Pages 1 Intilities 1 Inty or oth		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3	XRemoval from Sta	e C	emetery, crer	sition (Name of natory or other place		Date /12 /2006		Location - City or To	
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Battime permit. Pag Department important: I eny injury o		21. Signature of Funeral Service Lic	Stote	terry	2 Ed	lward Sag 191 Rockv	el Fu ille	neral Dir Pike, Roc	ectic kvil	n, Inc. le, Maryla	and 20852
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus y one cause on each	ed the death line.	n. Do not ent	er the mode of dyin	g, such as	cardiac or respirato	ry arrest,		Approximate Interval Between
Pnysician	1	Immediate Cause (Finat disease or condition	CONG	セミナル	E	HEAP	7	HAILUK	E		Onset and Death
/Medical Examiner		resulting in death)	Due to (or a	as a consequ	uence of):						
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nsit		cause. Enter Underlying Cause (Disease or injury	200 (3 (6)	.5 & 001150qt	201100 017.						
b, execu n end ial-tra	Exa	that initiated events resulting in death) Last	Due to (or a	is a consequ	uence of):	·					-
.U. BOX 68 / 6U, the death certificate be executed y the attending physicien end tched for use as the burial-transit	licai		d								
d ph diffical as the set that	Jed -	15.551111.5									
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d by letach		Part II. Other significant conditions	contributing to death	but not rocu	ulting in the Or	dorhing course div	on in Dort I	220 [aid tobaco	use contribute to the	an agus of death?
VITAI HECOTIAS, P. initian: The law requires that centificate has been signed b rector, page 2 should be detailed.		CHPONIC C	BSTRUC	TIVE	R	ILMONA	Ref)	1. Mars	Yes		v
as be	Сотрыете	CHRONIC 1-	HTRIAL	FIR	RILL	7710N			Vas an utopsy	24b. Were auto	psy findings available impletion of cause of
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or VITAI Ke		25. Was case referred to medical examiner?					-	of Death (Check o	nly one)		
hys side	0	1 Yes 2 No	Hospital: 1 ☐ Inpa		ER/Outpatien		4 Nur			6 ☐Other (Specif	y)
on on of ding P. After the funeral	0	27. Manner of Death 1. ☑ Natural 5 ☐ Pending		Day Year)	28b. Time of tntury	Worl	yaτ k? Yes 2.∐.N		ibe now in	jury occurred	
JOVISION OT VITA I or Attending Physician: after death. Director: After this certific. I in by the funeral director.	S	2 Accident investigati 3 Suicide 6 Could not	be Gen Black of I	niurv · At ho	me farm str	eet, factory, office	103 2		on (Street	and Number or Rura	N Route Number
d in b	Certification:	4 Homicide determine		etc. (Specify		out, rabidity, billion			Town, Sta		
To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier Check only one)	Physician: To the besiminer: On the basis and manner	of examinat	wledge, death tion and/or inv	occurred at the time restigation, in my of	ne, date and pinion, deat	f place, and due to h occurred at the ti	the cause me, date a	(s) and manner as s nd place, and due to	tated. the cause(s)
ithin of the office of the off	ğ Z	29b. Signature and title of certifier	and marmer	siated.		29c. License	e number		29d. E	Date signed (Month,	Day, Year)
1/		Masuella	Look	Q12		Da	9-12.	5		cember 11	
16	-	30. Name and address of person wh	completed cause of	death (Item	23a) (Type.	Print)			1		
	+	TASNEEM	LAKHAI		220	PARK	HEIC	Atts /	NE	BALD	M1) 2/208
State	-	31. Date filed (Month, Day, Year)		strar's Signa	ture	P					
Registra	r	DEC 12	2006	Green -	15.	DEALL					

			For State Registrar	State of N	/larylan	•	artmen tificate				lental Hy	giene Reg. No.	200c	41387
	Physicia /Medic		Decedent's Name (First, Middle, Last) Mona Michaels P								2. Date of De Month Decembe	Day	2006 Year	3. Time of Death 8:30 P M
	Examin		4a. Facility Name (If not institution, give s	treet and numbe	er)		4b. City,	Town, or	Location of	of Death			County of Dea	
			13 Over Ridge Cour				Poto						ntgome	
	Funeral Director		133-38-8365	M 2187 F	58	(ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da June 5	th ay, Year) , 194	Co	thplace (State or Foreign ountry) York
	and m		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation		 .					10d. Inside City Limits
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	ne 23	era	13 Over Ridge Cour	12. Was Deceder	nt Ever in U	.S. 13. V			ispanic Ori	igin? (Spi	ecify Yes or No		14. Race - Ame	erican Indian,
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218	c * 3	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4a	r 5+)	life.	kind of wor DO NOT us	se retired	during mos I)	t of work	ng	Mon	tgomery	County
7	be filed withing that Hygiene. Ind other than event, the M	Completed		5+		Socia	1 Wor	ker					ernment	
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٦	should be ind Mental marked o umatic eve	은	Harry Michaels 19a. Informant's Name/Relationship (Type)	oe. Print)		19b. Mailir	na Address	(Street a			Goldste		r Town, State, .	Zin Code)
₹	d 2 in the art train		Murray M. Pollack-								otomac,	_		<i>Lip</i> 3333)
a)	s 1 an of Heal Item 2 other	38	20a. Method of Disposition		20b. P	Place of Dispo cemetery, cren		_			Date	-	cation - City or	Town, State
E	Page nent o int: If		1 ⊠Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta						12/0	6/2006	Cla:	rksburg	, MD
Baltimore,	permit. Pages Department of H Important: If Ite any Injury or of		21. Signature of Funeral Service License	*		ED 1.0	Name and	d Addres SAGI	s of Facilit EL FU	NERA PTKE	L DIREC	TION	, INC.	LAND 20852
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Records,	w requires t been signe should be o	ed by	- Tarin. Still digital contains to				idenying ca	ause give	311117 (31)	-			_	robably 4 🛣 Unknown
ecc	aw is t	Completed									24a. Was	an	24b. Were au	utopsy findings available completion of cause of
	pag ate	Con									perfo 1 ☐ Yes	rmed?	death?	2 □ No
/ita	ysiclan: The is certificate director, pag	Be	25. Was case referred to medical examiner?	loopital:				104			(Check only			
ot	g .e. ₹	. To	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ospital: 1 Inpa 28a. Date of Ir		ER/Outpatien			4 🗀 140	-			6 □Other (Spe	city)
G .	ding h. After funer	ton	1 ☑Natural 5 ☐ Pending	(Month, L	Day Year)	Injury	M	8c. Injun Work	γαι ∢? Yes 2 🔲		28d. Describe	now injur	y occurred	
Division of Vital	I or Attending after death. Director: After d in by the fune	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of	Injury - At ho	ome, farm, str				-	28f. Location (Street and	d Number or Ri	ural Route Number,
á	safte safte al Dire	Certification:	4 Homicide	building,	etc. (Specif	y)					City or To	wn, State)	
	To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the be ner: On the basis and manner	of examina	wledge, death tion and/or in	occurred a	at the tim	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	s stated. a to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c	License	number				e signed (Mont	
	1		Raher BUK	men.	NO			D52	911			Dece	ember 6	, 2006
2	5		30. Name and address of person who co	mpleted cause of	f death (Item						20007			
			Robert Warren, MD	3800 Re	servo	ir Roa	d Wa	shin	gton,	, DC	20007			
	Sta	te	31. Date filed (Month, Day, Year) DEC 11 2006	Z. Regis	strar's Signa	ture	Ne D							

			For State Registrar	State of Ma	aryland		rtment of l		nd Mer		- /	2005	413	888
			Decedent's Name (First, Middle, I	Last)				Dodin	2.	Date of Dea	Reg. N6. ath	. 0 0 0	3. Time of	Death
	Physici	_	Pirapun Pocha	napimol						Month	Day	, 2006	11:55	рм
	/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town,	or Location of		CCCIIID	T	County of Dea		Р
	- LAGITIII	101	Holy Cross Hos	nital			C+ 1	r Spri	~~		D/I			
	Funeral			. Sex 7. Age	e (In yrs. la	st birthday)	If Under 1 Year	If Under 24	4 Hrs. 8.	Date of Birtl	h	ontgome 9. Bir	thplace (State o	or Foreign
ш	Director		213-15-7287	1 □ M 2 😡 F	79	Yrs.	Months Days	Hours		(Month, Day une 2		927 Tha	ountry) iland	
	p .		Usual Residence of Decedent 10a. State 10b. County		100 City	Town or Loc	antina.							in a lamina
	anyla shov	5	Toa. State Tob. County		Toc. Oity,	TOWIT OF LOC	ation						10d. Inside C	ıty Limits 2 √y No
	28a-1	Director	Maryland Montg 10e. Street and Number	omery		Silve	Spring				10- 00	414/5-4-0		
	with			2			10f. Zip Code					zen of What Co	ountry?	
	eath	erai	9017 Garland 11. Marital Status	Avenue 12. Was Decedent [Ever in U.S.	13 W	20901 Vas Decedent of	Hispanic Origi	in? /Specify	/ Yes or No-	USA	14. Race - Ame	erican Indian	
36	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other than "naturet", or iteme 23a or 28a-f show aumatic event. Ine Marylcel Examiner must be muilified at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?		If	Yes, specify Cut ☐ Yes 2 No	an, Mexican,	Puerto Rica	an, etc.)		Black, White Specify: Asi	te, etc.	
8	ture File	ed	15. Decedent's			16a, Deced	ent's Usual Occu	pation			16b Ki	nd of Business	/Industry	
15	in 72	Completed	(Specify only highest of	grade completed)		(Give I	kind of work done ONOT use retire	during most o	of working		100.10	na or basinosa	, maastry	
21215-0036	iene.	E	Elementary/Secondary (0-12)	College (1-4or 5)+)	Sea	amstress			:		Clothi	.ng	
	e filed Il Hygid other	0	17. Father's Name (First, Middle, La	st)				18. Mother	's Name (Fi	irst, Middle,	Maiden	Sumame)		
<u>a</u>	uid be Aental rked o tic eve	To B	Unavailable Po	chanapimol				Unava:	ilabl	е				
	2 should and Men is marke aumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Stree	and Number	or Rural Ro	oute Numbe	r, City o	r Town, State,	Zip Code)	
	and 2 salth n 27 i	١.,	Elynne Tooky B	unnag/ Niec	е	9017	Garland	Avenue	, Sil	ver S	rin	, MD 2	0901	
Baltimore,	Pages 1 and 2 should ment of Health and Mer ant: If Item 27 is marke ury or other traumatic	1 6	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□Removal from State	20b. Pla	ice of Dispos metery, crem	sition (Name of atory or other pla	ice) De	Date ecembe		20c. Lo	cation - City or	Town, State	
Ě	Pag ment ant: ury c		4 □ Donation 5 □ Other (Spe		Metro	politan	Cremator	7	2006		lex	andria,	Virgin	nia
Za Za	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lic	ensee			de le la la la la la la la la la la la la la							
_	<u>0</u> 0.5 € 0		Janugene	Herlen-			00 Unive					r Sprin		
		13	23a. Part1. Enter the disease, or of shock, or heart failure. List on	mplications that caused by one cause on each lin	the death. ne.	Do not ente	r the mode of dy	ng, such as ca	ardiac or re	spiratory ari	rest,		Approximat Interval Bet Onset and I	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	Sepsis									Days	Doalii
	/Medical Examiner		resulting in death)	Due to (or as										
		-	Sequentially list conditions,	b. Urinar			ection	_					Days	_
	nsit	-lu	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			3.1,5								
	execu n and al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ance of):						_		
8760,	icate be executed physician and s the burial-transit	dicail		d.										
68	tificat ig phy as th	0			TT. 12774				110.00					
Вох	leath certific ettending pl	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnance		Ectopic pregnanc	4			2	23d. Date of de	livery	
	deat	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at			Other (specify) _	· y				Month	Day *	Year
О	that the de led by the e detached f	h Si	9 Unknown								_		-	
Ś	8 50	ρ	Part II. Other significant conditions		ut not result	ting in the un	derlying cause gi	ven in Part I.	- 1				the cause of d	
oro	w requir been si should I	ted	Congestive Heart	rallure						1 U Y	es 2[_No 3 _ Pi	obably 4 🖟	Jnknown
Records,	e law hesb je 2 st	Completed							_	24a. Was a autop:	sy	prior to	topsy findings completion of c	available ause of
<u>~</u>		Ç								perfor 1 ☐ Yes		death? 1 ☐ Yes	2□No	
<u> </u>	ysician: The is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:					of Death (C)	heck only or	18/			
ō	Physician: r this certific ral director,	٠ <u>۲</u>	1 Yes 2 No 27. Manner of Death	1 Minpatie		R/Outpatient 28b. Time of	3 DOA			5 Resid		Other (Spe	cify)	
o	Jing After fune	tjon	1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year)	Injury	28c. Inju Wo M 1	rk?]Yes 2. □No		Describe in	Ow injury	y occurred		
Division of Vital	or Attending efter death. Director: Afte in by the fune	fica	3 ☐ Suicide 6 ☐ Could not	be 290 Blace of Inju	ury - At horr	ne, farm, stre				Location (S	treet and	d Number or Ri	ural Route Num	ber
á	el or A efter I Dire	Certification:	4 Homicide determine	building, etc	c. (Specify)		•			City or Tow	n, State,)		
	To the Hospitel or Attent within 24 hours efter death To the Funaral Director: completely filled in by the	edicai (29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examination	ledge, death on and/or invi	occurred at the ti estigation, in my	me, date and opinion, death	place, and occurred a	due to the c	ause(s) late and	and manner as place, and due	s stated. to the cause(s)
	To the h within 24 To the R complete	Me	29b. Signature and time of certifier				29c. Licen	se number		Z	29d. Date	e signed (Mont	h, Day, Year)	
)	ut-		July .	a un —	>		i i	032332			Dece	ember 7	, 2006	
			30. Name and address of person wh	o completed cause of de	eath (Item 2	23a) (Type, F	Print)							
			Suresh Gupta, M.				ue, #220), Silv	er Sp	oring,	MD	20902		
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 1 2	006 Registra	ar's Signatu	Sone.	les .							

06-09294 Jae Hee Park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ae nee Paik	1-For State Certificate of Death Reg. No. 2006	1.138
Physician Medical Examine	Month Day Year	ne of Death 30
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d0 University Boulevard East Apt. 404 Silver Spring Montgomery	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace	(State or
Director	213-15-6825 1XM 2 F 79 Yrs. Months Days Hours Min. 11/05/1927 Counts.	Korea
s. any	10a. State 10b. County 10c. City, Town or Location 10d. In	Inside City Limits
Maryland 28a-f show d at once.	MD Montgomery Silver Spring 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	Yes 2 X No
the state of the s	440 University Blvd.East #404 20901 USA	
r death with or items 23 c must be no	11. Marital Status 1 Never Married 2 Married 2 No Married	dian, Black,
s after c	3 Widowed 4 X Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: ASia	
5-0036 led within 72 hours after dygiene other than "natural", the Medical Examiner Committed by	Elementary/Secondary (0-12) College (1-4 or 5+)	·
d withir ygiene the Medi	12 unemployed none 17 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname)	
21215-0036 Uld be filed within 7 Mental Hygiene marked other than event, the Medica	Byung Ki Park Po Yong Yun	<u></u>
MD 21 dd 2 should dith and Mer m 27 is man aumatic ev	Chung Ahn/Grandson	hesda,
	20a Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crem. 20b Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crem. 12/09/06 Beltsville	
Baltimore, permit. Pages I as Department of He Important: If ite	4 Donation 5 Other Specify:	
M 링크트트 Physician	21. So the e of Funeral Service Licensee 22. Name and Address of Eachity PHILIP D. RINALDI FUNERAL SERVICE, 9241 Columbia Blvd.Silver Spring, 23a. Part I. Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appr	Md20910
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease Complicated by Drowning	ween Onset and Death
-	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
red nsit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	
uted uded and Francit	events resulting in death) Last Due to (or as a consequence of):	
760, icate be executed physician and the burial - transit	UNPENDED AMENDED	
x 6876 h certificate tending phy use as the l		Year
for at at	1 Yes 2 No 9 Unknown Unknown 5 Other (Specify)	
, P.O. Bries that the designed by the detached the detached the detached the detached the detached the Detach	1 Yes 2 No 3 Probably	
Records, The law require, freate has been sig. spage 2 should be	24a. Was an 24b. Were autopsy f autopsy prior to complete	
tal Recc cian: The lav certificate ha	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
Vital I	25. Was case referred to medical examiner? Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene	e
Division of Vital Records, tat or Attending Physician: The law require its after death al Director: After this certificate has been sited in by the funeral director, page 2 should be refification: To Be Completed	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 2 No Subject drowned	
Division o Spiral or Attending sours after death neral Director: After filled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be Dec 6, 2006 0900 hrs Dec 6, 2006 0900 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)	ute Number, City
Divi Hospital or . 24 hours after Funeral Dir tely filled in l	4 Homicide determined (Specify) Multi-Family Apt. 440 University Blvd East # 404, Silver Spr	ring, MD
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated	e(s)
3	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Da) December 7, 2006	y, Year)
	30 Name and address of person who completed cause of death (Item 23a)	
Stat	Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Meet Day Year) 2006 38 Registrar's Signature	
Registra	Heli I IIII Man III Ma	

Amended Items 5 & 10d per F.D. 12/12/2006 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Mar Registrer		rtment of Health tificate of Deat	-	giene 006	41390
Physic		1. Decedent's Name (First, Middle, Last) Thelma Miriam Pool			2. Date of D Month December	Day Year	3. Time of Death 3:20 P M
/Medi Exami		4a. Facility Name (If not institution, give street and number) Carroll Lutheran Village Heal	lth Care C	4b. City, Town, or Location		4c. County of Dear	
Funeral Director		393-221578- 1□ M 2♀F 91	(In yrs. last birthday) Yrs.	If Under 1 Year If Und Months Days Hour	ter 24 Hrs. 8. Date of B s Min. April	^{9. Bin} 22, 1915 Au	thplace (State or Foreign buntry) rora, MN
ryland how			10c. City, Town or Loc	cation			10d. Inside City Limits
he Ma 28a-f a	Director	MD Carroll 10e. Street and Number	Westminste			10g, Citizen of What Co	1 X Yes 2√No
3a or	i Di	205 St. Mark Way, Apt. #215		10f. Zip Code 21158		USA	ountry?
death	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	ver in U.S. 13. V	Vas Decedent of Hispanic Yes, specify Cuban, Mexic	Origin? (Specify Yes or N		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow pay injury or other traumatic avant. The Medical Examinar must be notified at 2008.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:		☐ Yes 2 ☐ No Special			hite
n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give l	ent's Usual Occupation kind of work done during m OO NOT use retired)	nost of working	16b. Kind of Business	/Industry
led with lygiene her the		4	Homema		other's Name (First, Middle	Own Home	
ild be file lental Hy ked oth	To Be	17. Father's Name (First, Middle, Last) Emil Haaya			hanna Matson	,	
2 should and Men is marke	-	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Nun			Zip Code)
1 and Health em 27		Kenneth W. Pool - Son 20a. Method of Disposition	1308 S	Somerset Ct.	, New Windso	er, MD 21776 20c. Location - City or	Town State
Pages nent of t		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crem	natory or other place)	1	Milwaukee,	
permit. Pages Department of Important: If I any injury or one.		21. Signeture of Fuperal Service Licensee			ritts Fu	neral Home	& Chapel, P.
40540		23a, Part 1. Egyer the disease, or complications that caused the	4	12 Washington	n Rd., Westm	inster, MD	21157 Approximate
Physician /Medical Examiner		shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)	consequence of):	rortu	store	4	Interval Between Onset and Death
ficate be executed ficate be executed physicien and is the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):				
The law requires that the death certificate sie hes been signed by the attending phy page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	iivery Day Year
w requires that been signed b	þ	Part II. Offer significant conditions contributing to death but	not resulting in the un	nderhying cause given in Pa	There	tobacco use contribute to	o the cause of death?
n: The law icete hes bur page 2 st	Completed				24a. Wa auto per 1 🗆 Yes	s an 24b. Were au prior to prior to death? 2 No 1 □ Yes	utopsy findings available completion of cause of
Physician: this certifice	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	t 2 ER/Outpatient	Othor: *	ace of Death (Check only Nursing Home 5 Res		cifv)
ing Ph After th	on: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Oay)	28b. Time of	28c. Injury at Work?	28d. Describe	how injury occurred	
i or Attanding after death. Director: Afte in by the fune	Certification:	Accident investigation Accident investigation	y - At home, farm, stre (Specify)	M 1 ☐ Yes 2 eet, factory, office	28f. Location	(Street and Number or Roown, State)	ural Route Number,
To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medical Co	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of e and manner state	xamination and/or inv	occurred at the time, date restigation, in my opinion, o	and place, and due to the death occurred at the time	e cause(s) and manner as , date and place, and due	s stated. s to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier		29c. License numbe	ər	29d. Date signed (Mont	h, Day, Year)
MJL		Structo, D.O.	ath (Item 22a) (Time-	HEOS.	5845	12/12/	2006
12		30. Name and address of person who completed cause of dea	13 80 PZ E	GRESS 1	WAD EL	derestura	2. Hd.
St Regist	ate trar	31. Date filed (Month, Day, Year) 32. Registrar' DEC 1 2 2005	's Signature	Societies			

			1 - For State Registrar	State of Marylar		artment rtificate					Reg. No.	106	41391
	Physici /Medio		Decedent's Name (First, Middle, La SENITA	st) QUEE1	N.					2. Date of Dea Month DECEMB	Day	2006	3. Time of Death 8:09A M
	Examir		4a. Facility Name (If not institution, given 6320 SEAT PLEAS	ANT DRIVE		SEAT	PLE	Location of EASANT			PRI		EORGE'S
A.	Funeral Director		5. Social Security Number 6. S 579-94-2635 Usual Residence of Decedent	ex 7. Age (In yrs. 33	last birthday) Yrs.	If Under 1 Months	Days	If Under 24 Hours	4 Hrs. 8	B. Date of Birt (Month, Da) DEC • 1	k, Year) 8 1972	9. Birthi Cou MAR	place (State or Foreign ntry) XYLAND
	se Maryland	Director	MD 10b. County PRINCE		y, Town or Lo		rs	_					10d. Inside City Limits 1 Yes 2 □ No
	with the age of 21 to a control of the control of t	Dire	10e. Street and Number 6320 SEAT PLEASA	NT DETUE		10f. Zip 0		0			10g. Citizen U.S.A		ntry?
036	d within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28s-f ehow the Madical Exeminer roust be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:					in? (Spec Puerto Ri	ify Yes or No- can, etc.)	14. F	Race - Ameri Black, White,	
Maryland 21215-0036	within ane. than	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12th	ducation ide completed) College (1-4or 5+)	(Give life.	dent's Usual kind of work DO NOT use	done d retired,	lu <i>ring</i> most o	of working	7		f Business/In	dustry
land 2	be filed stal Hyg ed othe event,	To Be Co	17. Father's Name (First, Middle, Last, JAMES CANADA		110011			18. Mother's	,	First, Middle,	Maiden Sum		
	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (BRENDA QUEEN/SIS	STER	6320	SEAT :	PLEA		DRIV		TOL HE	IGHTS	MARYLAND 20743
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Place of Dispo cemetery, crei ARMONY	natory or oth CEMET	er place ERY	1		/2006	LANDO		ARYLAND
Ball	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Cen	nsee /						B. JEN LANDOV			L HOME 20785
	Physician /Medical Examiner	ıer	23a. Peart. Enter me disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	ANCER uence of):	er the mode	of dying	g, such as ca	ardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
,8260,	death certificate be executed e attending physician and of for use as the buriat-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):								
P.O. Box 68	it the death certifica by the attending phi tached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ildeath 3□	Ectopic pre						Date of delive	ery Day Year
	signed d be de	þ	Part II. Other significant conditions of ACQUIRED IMMUN			nderlying cau	use give	in in Part I.					he cause of death?
Il Records,		Completed							_	24a. Was autop perfor 1 Yes	sy med?	prior to co death?	opsy findings available impletion of cause of
Vita	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	r-		Check only o			
Division of Vital	our eur	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		c. Injury Work	+ <u> </u>	28	e ≸© Resid d. Describe h			(y)
Divis	- 9	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory,	office		28	f. Location (S City or Tow		mber or Rura	al Route Number,
	To the Hospital of within 24 hours af To the Funeral completely filled in	edical	29a. Certifier (Check only one)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death	h occurred at vestigation, i	t the tim in my op	e, date and inion, death	place, an	d due to the o	cause(s) and date and plac	manner as se, and due to	stated. o the cause(s)
	To the Vithin 2 To the Complet	W	29b. Signature and title of certifier	(lun)	ans	D.5	License	number 8			DECEM		Day, Year) , 2006
	(6)		30. Name and address of person who DIVYA VERMA F. I 31. Date filed (Month, Day, Year)	. 7525 GREENWA	Y CENT	CER DR	IVE	#202	GREE	NBELT,	MARYLA	ND 207	770
	Sta Registi		DEC 1 2 2006	Server G.	Spen	Ü							

			For State Registrar	State of M	larylan			nt of He te of D		Menta		ene g. No. 200	6 41392
	Physici	an	1. Decedent's Name (First, Middle, Las							Mo		Day Yea	3. Time of Death
	/Medic		KATHERINE QUIC								ember	6, 2006	5:00p M
	Examir	er	4a. Facility Name (If not institution, give LAUREL REGIONAL H)				Location of De	ath		4c. County of De	
-	Funeral		5. Social Security Number 6. S		ge (In yrs.	last birthday)	If Unc	Laure] er1 Year	If Under 24 H		e of Birth	PrinceGe	Birthplace (State or Foreign
	Director		219-12-3429	□M 280F	96	Yrs.	Month	s Days	Hours Mi	Jan	onth, Day, 30,	1910 Mai	Country) ryland
	P		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	nation						10d. Inside City Limits
	Aaryka r eho	5											1½ Yes 2 □ No
	28a-	Director	MD Prince G	eorges	_ be.	ltsvil		ip Code			10	g. Citizen of What	Country?
	h with	O IE	11342 Evans Trai	1 #202				20705				USA	
	ame i	Funeral	11. Marital Status	12. Was Deceden Armed Forces		.S. 13.			panic Origin? , Mexican, Pu	(Specify Ye	s or No-		merican Indian,
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give	No			2 🔀 No	Specify:		-10.7	Specify:	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other than "natural", or Itame 23s or 28s-f ehow aumatic event, the Medical Examiliar must be invalible at	ed b	15. Decedent's Ed	Year or Dates:		16a, Dece	dent's 11s	sual Occupa	tion		1	6b. Kind of Busines	Black
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7	filed with Hygiene other the	E O	7th	College (1-40)	3+1	Rece	epti	onist				Lord & Ta	aylor
Maryland	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)							-		laiden Sumame)	
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<u>a</u>	id 2 sl Ith and 27 is r traur		19a. Informant's Name/Relationship (7) Melvalee M. Will		r		-					City or Town, State . 20706), ZIP COG9)
ē,	s 1 ar f Hea item other		20a. Method of Disposition		20b. P	Place of Dispo				Date		Oc. Location - City	or Town, State
altimore,	Page nent o int: If		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		,	yland :				-15-20	06 1	Laurel, M	D.
Balti	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e and e.		21. Signature of Funeral Service Licen	see	00)	Ma	Name arsh	and Address	of Facility Funera	1 Home	e, In	c.	
			23a. Part 1 Enter the disease, or comp	olications that cause	d the death				. N.W.			on, DC 20	0011 Approximate
	Physician		23a. Part Exter the disease, or composition of shock, or heart failure. List only Immediate Cause (Final								,		Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a. Left Ce			lar A	Accide	nt				2 day
	Examiner		Conventially list conditions	Arterio		,	Card	iovasc	ular D	iseas	2		
	p =	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a conseq	uence of):							
	and and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	s a consequ	uence of):							
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89	tificate ig phy as the		1200	, U									
Š	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic	pregnancy				23d. Date of c	
P.O. Box	The law requires that the death certif site hes been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	4⊟Pregnant a 9⊟ Unknown	at time of d		Other (Month	Day Year
	that the ed by detac		Part II. Other significant conditions of	ontributing to death	but not resi	ulting in the u	nderlying	cause giver	n in Part I.	23	e. Did toba	acco use contribute	to the cause of death?
Division of Vital Records,	juires that n signed b	d by	Dehydration and								1 🗌 Yes	s 2,⊟tNo 3 □	Probably 4 Unknown
<u></u>	s been s shoulk	lete								24	a. Whas an	24b. Were	autopsy findings available
8	eicien: The law s certificate hes t irector, page 2 s	Completed								10	autopsy perform Yes 2	ed? death'	o completion of cause of ? es 2 (2XNo
ā	sian: artifica ctor, p	Be C	25. Was case referred to medical examiner?						26. Place of D	1			2 (22,110
>	> 0	٦ و	1 ☐ Yes 2 🖾 No			ER/Outpatien			4 🗆 Nursing			nce 6 Other (Sp	pecify)
ב	ding Ph. h. After th funeral	:lon:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury	М	28c. Injury Work?	at ? es 2 ∐ No	28d. De	scribe hov	v injury occurred	
<u>isi</u>	or Attendatifier death	flcat	2 Accident investigation 3 Suicide 6 Could not be determined	1	niury - At ho	ome, farm, str			93 2 110	28f. Loc	ation (Stre	et and Number or	Rural Route Number,
á	el or s s after of Dire	Certification:	4 Homicide	building, e	itc." (Specify	y)		,,,,		City	y or Town,	State)	,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical (29a. Certifier 1 Certifying Ph	ysician: To the besi	of examina	wledge, death tion and/or inv	occurre vestigation	d at the time	e, date and pla nion, death oc	ce, and due	to the car e time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and manner s	Z		2	9c. License	number		29	d. Date signed (Mo	nth, Day, Year)
	->-0			100	0	MI	8	D24	721		D	ec. 7, 20	006
)	(3)		30. Name and address of person who	completed cause of	death (Item	1 23a) (Type,	Print)						
			7 1-	14333 Lau				St. 2	08 La	urel,	MD.	20708	
1	Sta Registr		31. Date filed (Month, Day, Year) TEC 1 2 2006	32. Regist	rar's Signa	bed	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:20 A M December Marie onna 2066 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns nmore Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 6/19/50 Year) Months Days 1 □ M 2 X F 210-34-3082 56 Director Missouri Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 □Yes 2 No VA Arlington Arlington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22204 USA 822 S. Arlington Mill Dr. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify. White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5**+** Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward F. Roeder Gloria E. Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 251 Prospect Bay Dr. West Grasonville, MD 21638 Shirley E. Hoisington-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12/10/06 Cremation Center Chantilly, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ²² Name and Address of Facility
Murphy Funeral Home
4510 Wilson Blvd. Arlington, VA Line Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Acute Myelocytic 7 months /Medical Due to (or as a conse uence of) Examiner Sequentially list conditions, if any leading to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the huria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 24 No certificate the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000 2006

CR(12)

State Registrar 31. Date filed (Month, Day, Year)

TFC 0 8 2006



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saltimore

		4	For State	State of Maryla		artment of H			/ / / / / /	41394
			Registrar 1. Decedent's Name (First, Middle, Last)		- 06	Tuncate of I	Jean	2. Date of Deat	eg. No. be	3. Time of Death
	Physicia			gia Mary	7 Ro	50		Month	Day Year	6:00 p M
	/Medic	al	Luciana Geor 4a. Facility Name (If not institution, give s		KO		Location of Deat	Decembe	4c. County of Deal	
	Examin	er	Calvert Memorial				ce Frede		Calve	
	Funeval		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	9 Rin	hplace (State or Foreign
	Funeral Director		213-40-6442	M 2∏ F 8	7 Yrs.	Months Days	Hours Min.	Nov. 5,		Italy
	ס		Usual Residence of Decedent							10d. Inside City Limits
	how thow		10a. State 10b. County	10c. 0	City, Town or Le	ocation				1 Yes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if haalth and Mental Hygiene. If the sith and Mental Hygiene. If the sith and Mental Hygiene is the marked other than "naturelt, or items 23a or 28a-f show other traumatic event, the Madisal Examinar must be notified at	cto	MD Calvert		Sunder.				Og. Citizen of What Co	21
		Director	10e. Street and Number			10f. Zip Code	600	'		1
	ath v	E	5030 Sunnyhills D	Drive 12. Was Decedent Ever in	11.0 12		689	Specify Ves or No-	U.S	
	er de item	nue	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 Yes 2 MNo	0.3.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Black, Whit	
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Š	2 hou	bed	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occup	ation	dina	16b. Kind of Business	/industry
21215-0036	hin 7.	Completed	(Specify only highest grade	College (1-4or 5+)	life.	DO NOT use retired	d)	nking .		
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yla	Ment Ment arke	ည		lacci			Ada		alsina	7'- Ondo
Maryland	2 sh and is m		19a. Informant's Name/Relationship (Ty			Sunnyhil			r, City or Town, State, and MD 206	
e,	s 1 and 2 of Health of item 27 i		Arthur F. Rose, hu		. Place of Disp	osition (Name of			20c. Location - City or	
Baltimore,	or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State		matory or other pla		/14/2006	Alexandria	177
量	it. Pe		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License						neral Home	
Ba	permit. Peges 'Department of H Importent: If Ite any injury or of	, 13	The state of the s	A colores					ings, MD 20	
			23a. Part1. Enter the disease, or compli	cations that caused the de						Approximate Interval Between
	Dhuaisian		shock, or heart failure. List only or Immediate Cause (Final		0	1200 L. 1	Jan-10			Onset and Death
).	Physician /Medical		disease or condition resulting in death)	Due to (or as a cons	sequence of):	1111/7	F/11)1 Q			
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8760,	2 2	dical		d		<u></u>				
9	death certifica e attending ph ed for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome of pre-	gnancy				23d. Date of de	livery
Вох	atten for us	Jan	23b. Was decedent pregnant 1							
o.	by the de	ysic	1 Yes 2 1 No 9 Unknown	9☐ Unknown						
Q	g B B		Part II. Other significant conditions co	ntributing to death but not	resulting in the	underlying cause gr	ven in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
rds,	quires n sign ald be	ed by	Atrial Fit	millation	2			1 🗆 Y	′es 2□No 3□F	robably 4 🗹 Unknown
Record	s been si	ojete	Consestive	Heart	- Fo	ilure		24a. Was autop	an 24b. Were a	utopsy findings available completion of cause of
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Vital		0	25. Was case referred to medical	77761176			26. Place of De	eath (Check only o	ne)	
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n of	ding Ph h. After th tuneral		27. Manmer of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year	28b. Time Injury	Wo		28d. Describe h	now injury occurred	
Sio	eath.	cati	2 Accident investigation 3 Suicide 6 Could not be]Yes 2 □No	29f Leastion /6	Street and Number or F	Pum I Pouto Number
Division	or Attending effer death. Director: After d in by the fune	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spi		treet, factory, office		City or Tou	vn, State)	arar noute reamber,
	pitel		29a. Certifier 1 Certifying Phy	sician: To the best of my	knowledge, dea	ath occurred at the t	ime, date and pla	ce, and due to the	cause(s) and manner a	as stated.
	To the Hospitel within 24 hours e To the Funeral I completely filled	Medicai	(Check only 2 Medical Examinations)	iner: On the basis of exam and manner stated.	rination and/or	investigation, in my	opinion, death oc	curred at the time,	date and place, and du	e to the cause(s)
	To the Hospitel or Atten within 24 hours efter deat To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier	20		29c. Licen	se number		29d. Date signed (Mor	
			ergan	r.c. su	-and	9. 1	506			- 2006
	2		30. Name and address of person who c	1	Item 23a) (Type	e, Print) GY	AIX -	c. SI	JRANA	0
	IJ			eale Ch 32. Registy s Si	words.	ton A	<i>toad</i>	Dea	ue mp	20751
	St. Regist	ate rar	31. Date filed (Month, Day, Year) DEC 1	2 2006 Marie		Courte	•			

			For State Registrar	State	of Mar	ylan				ealth a Death	and M	ental Hy	gienę Reg. No.		6	41395)
	Physici /Medio		1. Decedent's Name (First, Midd Martin Rosenber									2. Date of De. De Cethbe		200%	ar	3. Time of Death 12:38P _M	
	Examir		4a. Facility Name (If not institution, give street and number) Montgomery General Hospital					4b. City, Town, or Location of Death Olney					4c. County of Death Montgomery				
1d 21215-0036 Ified within 72 hours after death with the Maryland Hygiene.	Funeral Director		5. Social Security Number 140-22-6260 Usual Residence of Decedent	6. Sex 1(XIM 2□ F	7. Age (/	in yrs.	last birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da 1/26/1	th y, Year) .931	9.	Birthpla Cou <i>ntr</i>	ce (State or Foreign y) NY	
	a-f show	ctor	MD 10b. Count Montg	omery	1-		y, Town or Lo	cation							100	d. Inside City Limits 1 X Yes 2 □ No	
	23a or 28 ust be no	ral Director	10e. Street and Number 4029 Olney-Lay	tonsville	Road	1		10f. Zi	2083	2				ted S			
	rai', or items	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 ☑ Yes 2 □ Nit Yes, Give Year or Dates:			19555 13. Was I			s Decedent of Hispanic Origin? (Specify Yes es, specify Cuban, Mexican, Puerto Rican, et] Yes 2 <mark>菜</mark> No Specify:			cify Yes or No- Rican, etc.)	or No- c.) 14. Race - American Indian, Black, White, etc. Specify: White			c.	
	iene. r than "natu	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Systems Specialist Priva:							stry			
	Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Middle Henry Rosenber	, Last)		,	405 14 33		(2)	Anna	Whi	(First, Middle,		,			
	Health and sm 27 is m ther trsum		19a. Informant's Name/Relation Ilene Rosenber 20a. Method of Disposition			20b. P)lney	-Lay	tonsv	ille	Road O	lney		0832	2	_
Baltimor	Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic events.		1 Burial 2 Commation 4 Donation 5 Other (Specify)	JIAIO		ional	Crem	ator;	y s of Facility	12/ Dan	12/06	Fall Gold	s Chu	rch, Memo		p
on of Vital Records, P.O. Box 68760,	hysicien and burial-transit sthe burial-transit	dical Examiner	23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	each line. M (or as a c	lyoc onsequences 31ac Pros	cardia uence of): lder Ca uence of): state (l Inf	arct		cardiac o	r respiratory ar	rrest,		- 11	Approximate niterval Between Onset and Death	
	y the attending pached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 [nant at time	Fetal	Ideath 3[]Ectopic p] Other (s					2	3d. Date of Month		ay Year	
	n signed by the a	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension 23e. Did tobacco use contribute to the cause of death?														
		Completed	Diabetes					-			_			24b. Were prior deat	to comp	y findings available pletion of cause of	
	ath. r: Alter this certificete e funeral director, pag	atlon; To Be	25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident invest	Hospital: 1	26. Place of Death / Check only one) 27. Ospital: 1								_				
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To the Hospital	within 24 hours To the Fune completely fi	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	/ //	basis of ex nner stated	camina	wiedge, deat tion and/or in	vestigation	in my or	inion, deat	d plane a	ed at the time,	date and	place, and	due to th	ne cause(s)	_
)	15		30. Name and actures of person	n who completed car			,	Print)	D450.	568			12/9	/06		,	
	Sta Registr		31. Date liled (Month, Day, Year	d Kurnot 2- 32. 2 2006	MD 18 Registrar's	Signa	ture	e Ph		Drive	e #2	70 Olne	у МД	2083	2		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ROBERTA RUSSELL December 2006 11:40 P M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Ye) Feb. 22, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Year) Days Months Hours 81 307-20-8955 1925 IN Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 402 Rock Lodge Road United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Tes 2 XIII Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Assistant Medicine 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lawrence Shannon Nora Rogers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 402 Rock Lodge Rd. Gaithersburg, Md. 20877 Ann Aragon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 13, 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery Germantown, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home urtes 10 East Deer Park DR. gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respir year arrest shock, or heart failure. List only one cause or each line. Approximate Interval Betwee Onset and Dea Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events (or as a consequence of) resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

item 27 I

Pages 1 permit. Pages 1
Department of It
Important: If ite
any injury or ot

other

Physician

/Medical

Examiner

Funeral

Director

iral", or items 23a or 28a-f show Examiner must be notified at

the Medical

Director

Funeral

Completed by

Be

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and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. m 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed burial-transi and physician the as use certificate has

Division or Vital Records, P.O. Box 68760,

Hospital or Attending

To the I

death after ģ Be Completed

Examine Physician/Medical Certification: To After this neral Director: / within 24 hours aft

To the Funeral D

completely filled in

			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 V nknown								
			24a. Was an autopsy performed performed to a 24b. Were autopsy findings available prior to completion of cause of death? 1								
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 □ Yes 25 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DO	lome 5 ☐ Residence 6 ☐ Other (Specify)									
27. Manner of Death Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury M	28c. Injury at Work? 1 ∐ Yes 2 ∐ No	28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factor building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)									

	(Check only one)
29b.	Signature and

29a Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

William Dooley M.D. 9901 Medical Center Dr. Rockville, Md.20850

State Registrar

Medical

31. Date filed (Month, Day, Year 2006

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** DEC. BARBARA S. ROCHE 6, 2006 3:43 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MARCH 5, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 6. Sex **Funeral** Months 1 ☐ M 2 🕱 F Director 78 1928 INDIANA 309-26-6430 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or then "neturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director PRINCE GEORGES COLLEGE PARK MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4511 AMHERST RD. 20740 U.S.A. death , 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after al Hygiene. I other then "netural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No δ Specify: 3 X Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 ARTIST ART 17. Falher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 Is marked other Be WENDEL HANNA HENRIETTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANETTE ROCHE/DAUGHTER 4511 AMHERST RD., COLLEGE PARK, MD. 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò Department of Important: If eny injury or once. CHAMBERS CREMATORY Dec. 9,2006 RIVERDALE, MD. 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 18 birato /Medical Due to (or as a consequence of): Examiner NCine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a c equence of): Examine certificate has been signed by the attending physician and lifector, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed remia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 dusant Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2 121No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗀 No 1 ☐ Yes 2 1 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 PNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier O 0 63839 6 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PADMA CHIRUMAMILLA, M.D. 7600 CARROLL AVE., TAKOMA PARK, MD. 20912 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Month 12 04^{Day} 2006 Michael Clifton Robinson 8:30 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Tokoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 02/02/1952 5. Social Security Number Birthplace (State or Foreign Country)
 DC 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F 54 Yrs. Director 577-72-3243 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at MD Prince George's Mount Rainer 1⊠Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3332 Buchanan Street 20712 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. be filed within 72 hours after de Mal Hygiene Id other then "naturel", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1971 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Word Processing Operator Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental F Important: If Item 27 is marked of Lawrence Clifton Robinson Delores Johnson Robinson 19b. Maijing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5/6 West Court
Glen Burnie, MD 21061 19a. Informant's Name/Relationship (Type, Print) Cheryl A. Smith / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham Nat'l any injury o 12/12/2006 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3831 Georgia Avenue N.W. Latney's Funeral Home Washington, DC 20011 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown this certificate has been signed by the director, page 2 should be detact Part II. Other significant conditions contributing to death bilt not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2□ No 1 Yes 2 No 1 Yes After this certification funeral director, p or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Watural 5 Pending after death. 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled in Hospitel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ₽ 1 29c. License number 29b. Signature and title of certifier 29d. Date signe: (Monti, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL 1610 NASREEN ANGO 31. Date filed (Month, Day, Year) 2. Hegistrar's Signature State Registrar 2006

Amended Item 26 per Physician 12/08/2006 Carroll County, wjl
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No:-2. Date of Death 1. Decedent's Name (First, Middle, Last) December Day Year 2006 0915 M 7, **Physician** Elizabeth Reed Nancy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Carroll Lookabout Manor If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗶 F Yrs. 11, 1945 Maryland Director 61 216-48-3528 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-f show any injury or other treumatic event, Ina Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Directo Baltimore Parkton Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21120 17929 Masemore Rd. Funeral 14. Race - American Indian, Btack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify: White δ 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Alex Cooper Elementary/Secondary (0-12) College (1-4or 5+) 12 Graphic Artist Auctioneers 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Isabelle Harman Thomas McElroy ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21048 2201 Timber Lane Finksburg, MD Brother Thomas McElroy 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Cremation 12/8/06 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll 22. Name and Address of Facility Pritts Funeral Home & Chapel 21. Signature of Funeral Service Licensee Þ Westminster, 412 Washington Rd. $_{\rm MD}$ Approximate Interval Between Onset and Death 23a. Left1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition 400 6 mats **Physician** 0/00 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the ettending physician and shed for use es the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð pe 200 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Assisted Living Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Desidence 6 NOther (Specify) Facility ٩ 2 ER/Outpatient 3 DOA 1 🗌 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manher of Death 28c. Injury at Work? Certification: Matural 5 Pending investigation 2 Accident 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by Hospital or Attending Physician: completely filled in by the funeral director, this After death. Diractor: efter To the Hospital within 24 hours e To the Funerel I Medical

Baltimore, Maryland 21215-0036

State Registrar 29a. Certifier

29b. Signature and title

MD 31. Date filed (Month, Dey,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

			For State Registrar	State	of Maryl	•	artment of H			iene g. No2 0 0 6	41400
			Decedent's Name (First, Middle	e, Last)					2. Date of Death	7	3. Time of Death
	Physici		Thomas	Pur	Kma	^			Month 12	Day Year	0837 AM
	/Medic Examin		4a. Facility Name (If not institution			· · · · · · · · · · · · · · · · · · ·	4b. City, Town, or	Location of Death	16	4c. County of Dea	
	Lxaiiiii	E	Coastal Hospie	1.1.1	4 4.		Salisbur	N		Wicomi	
	Funeral		5. Social Security Number	6. Sex		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign
	Director		227-28-6028	1 2 M 2□F	79	Yrs.	Months Days	Hours Min.	(Month, Day, 6-9-192)		ountry) Cginia
	D		Usual Residence of Decedent							· , , , , , , , , , , , , , , , , , , ,	
	nyian ihow	_	10a. State 10b. County		10c.	City, Town or Lo	ocation				10d. Inside City Limits
	e Ma la-f	cto	MD Worce	ster		Berlin					1 ☐ Yes 2X No
	ih th or 28	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What C	ountry?
	23a		10518 Cathell	Road			2181	1		USA	
	r dear	Funerai	11. Marital Status	12. Was Dec Armed F	edent Ever i	n U.S. 13.	Was Decedent of Hill If Yes, specify Cubar	spanic Origin? (Sp. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	or it	by Fu	1 ☐ Never Married 2 📉 Mar	ned 1 X Yes If Yes, G	iv <i>e</i>	1945-	1 ☐ Yes 2 ☒ No	Specify:		Specify: W	
8	urei		3 Widowed 4 Divorced		Dates:	946					
5	within 72 hours after death with the Maryland ene. than 'naturel', or freme 23e or 28a-f ehow the Medical Exarit ar most be rivitified at	Completed	(Specify only highe	t's Education st grade completed))	(Give	dent's Usual Occupa kind of work done a DO NOT use retired,	turing most of work	ing	6b. Kind of Business	Vindustry
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d 2	e filed within al Hygiene. other than vent, it e mu	ပို	17. Father's Name (First, Middle,	Last)		stee	1 worker	18. Mother's Name		Steel Comp	any
an	d be antal red o) Be	John Thomas Ru						, ,		
<u>-</u>	2 should be and Mental le marked (2	19a. Informant's Name/Relations			19b. Maili	ng Address (Street a	Viola Ch		City or Town, State,	Zin Code)
E	ロモトニ	100	Jane Ruckman -			1051		1 Road, I		•	Lip Godo,
a,	Health tem 27 I		20a. Method of Disposition	WIIC	20	b. Place of Dispo	sition (Name of		Date 2	1D ZIOII 20c. Location - City or	Town, State
<u>0</u>	ages ant of it: If I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			-	matory`or other place Sy of Deln	112-00	3–06 _T	Delmar, DE	
Baltimore, Maryland 21215-0036	permit. Pages 1 an Depertment of Heal Importent: If Item 2 eny Injury or other ance.		21. Signature of Funegal Service				2. Name and Addres	4.5			
B	Depermination of the source once		Molley	Theren !	She	0		, Bo		neral Home	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the d	eath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	iry, MD 21 st,	Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Mc	tasta	sequence of):	Prostate		rec		Interval Between Onset and Death
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to	(or as a cons	sequence of):					
	icate be executed physicien and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
Ö,	e exe	EX	resulting in death) Last	Due to	(or as a con:	sequence of):					
8760,	ate b hysic he bi	dicai		d							
9	ing p	Med	IF FEMALE:				-				
P.O. Box	that the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		birth 2 ☐ F nant at time o	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	The law requires that ate has been signed b age 2 should be dete	by P	Part II. Other significant condition	ons contributing to d	leath but not	resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ë	w require been sig should b	ed						·	1 □ Yes	s 2/⊠No 3□P	robably 4 Unknown
Records,	aw requisites the second secon	Completed							24a. Was an	24b. Were a	utopsy findings available
æ	The lav	EO							autopsy perform		completion of cause of
Vital		e e	25. Was case referred to medica					26. Place of Death	1 ☐ Yes 7		- 20140
\geq	S 5	To B	examiner? 1 ☐ Yes ≥ No	Hospital:	Inpatient 2	P ☐ ER/Outpatier	nt 3 DOA Othe	-		nce 6 □Other (Spe	ecify)
0	g Ph ter th		27. Manner of Death	28a. Date		28b. Time o	28c. Injury Work		28d. Describe how		
<u>ö</u>	Attending r death. ector: Afte by the fune	atio	Natural 5 ☐ Pendir 2 ☐ Accident investi	g	iii, bay roar	, inquity		es 2 No			
Division of	al or Attend after death Director: / d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	1288. Place	e of Injury - A ling, etc. (Sp	t home, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R	ural Route Number,
Ö	ital or rs afte al Din led in I	Cer			g, (O.l.y O. 10,	3.4.0)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier Certifyir (Check only one)	Examiner: On the b	e best of my pasis of examiner stated.	knowledge, deat lination and/or in	n occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the car ed at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)
)	C Twite	Σ	29b. Signature and title of certifie	00	In	0	29c. License	number 入るファ	8 29	d. Date signed (Mont	th, Day, Year)
0	4,6		30. Name and address of person	who completed caw	se of death (1 1 1	1 '	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	22 10	1/ 200	2/15/23
1	7		31 Date fled (Marth Car	Kell, MS	(Da		USPILL H	X /	55	Why	11101
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0		enistrar's Si	yriature	Contin			\bigcup	
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			1- State of Maryland / Department / Department / Dep	artment of Health and rtificate of Death		giene 006	4 1401
			Decedent's Name (First, Middle, Last)		2. Date of Dea	ath	3. Time of Death
	Physici /Medi		Marvin Edward Sloan		Decemb	per 6 200	6 7:39 A
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Deat	h
			Doctors Hospital	Lanham		Prince (
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	. (Month, Day		hplace (State or Foreign untry)
	Director		248-46-4556 TAM 2 T 76 Yrs. Usual Residence of Decedent		Aug. 3,	1930 Sout	h Carolina
	land ow		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary	호	Maryland Prince George's	C1	D-1-		1 X Yes 2 □ No
	r 28a	rec	10e. Street and Number	Glenn 10f. Zip Code		10g. Citizen of What Co	untry?
	h witi	0	10016 Locust St.	20769		United	States
	deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	Specify Yes or No-	14. Race - Ame	rican Indian,
_ 9	after dea or Iteme	五	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☑ No Specify:	to Hican, etc.)	Black, White	
≥ 8	72 hours after death with the Marylan "naturet", or Iteme 23e or 28e-1 show idical Examinat must be notified at	d b	3 Widowed 4 □ Divorced Year or Dates:	TE 163 ZM 110 Specify.		Specify:	Black
arvin	filed within 72 hours after death with the Maryland Hygiene. the rhan "naturel", or Iteme 23e or 28e-1 ehow ent, the Madical Examiner must be motified a	Completed by Funeral Director	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wor	rking	16b. Kind of Business/	ndustry
7 2	withir ene. then	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
2 F	e filed within Hygiene.	ပို	17. Father's Name (First, Middle, Last)	cial Protective S	ervices me (First, Middle, .	Govern	ment
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Mary	shound M	-		ng Address (Street and Number or Ru			ip Code)
>\Z	s 1 and 2 should be filed f Health and Mental Hyg Item 27 is marked oths other traumatic event,		Marvin Eddie Sloan/Son	1203 Harvard St			
Je, e	os 1 and 2 of Health Item 27 i		20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place)	Date	20c. Location - City or	Fown, State
.O. E	permit. Pages Department of the Importent: If Ite any Injury or of once.		1 Burial 2 Cremation 3 Hemoval from State	Memorial park 12/	16/2006	Landove	r. MD
and the	permit. Pag Department Importent: any Injury once.				_	Funeral Hom	
/ 60	89 = 9		John I. Sleword The	4001 Benning			20019
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	c or respiratory arr	est,	Approximate Interval Between
	Physician	0	Immediate Causa (Final disease or condition	STIVE HEAR	LT PAI	LURE	Onset and Death
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	led nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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68760,	iicate be executed physicien and s the burial-transit	edical					
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Вох	th cer endin	N/us	IF FEMALE: 23b. Was decedent pregnant in the past 12 growth 2 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of deli	very
<u>.</u>	deat deatt	Physician/M	1 Yes 2 No	Other (specify)		Month	Day Year
P.O.	at the	h	9 El Oukuowu				
Ś	Attending Physiclen: The law requires that the death certif death. rotor: Atter this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.		bacco use contribute to	
Division of Vital Records,	w requir been si should	Completed	10N CW IN		1 🗆 Ye	es 2 □No 3 □ Pro	bably 4 Hhknown
ec	e 2 sl	nple			24a. Was a autops	y prior to o	opsy findings available ompletion of cause of
<u> </u>	cate				perform 1 ☐ Yes 2	med? death? 2.☑No 1 ☐ Yes	2□ No
Ž.	iclan certifi ector	Be	25. Was case referred to medical examiner? Hospital:	T.	ath Check only on	10)	
of	Phys this ral din	<u>P</u>	Inpatient 2 EH/Outpatien			ence 6 Other (Spec	fy)
o	ding h. After fune	tl on	1t☑Natural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	280. Describe no	ow injury occurred	
isi	Atten deat ctor: y the	flca	Supple Su		28f. Location (St	treet and Number or Ru	ral Boute Number
ă	al or after after I Dire	Certification:	28e. Place of Injury - At home, farm, structure determined	,,	City or Town	n, State)	ar rosto rampor,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place	, and due to the ca	ause(s) and manner as	stated.
	the Ho hin 24 the Fu	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or invoice)	estigation, in my opinion, death occu	irred at the time, da	ate and place, and due	to the cause(s)
	To the to the comp	Σ	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month	
			Alley MD	D005829	10	12/11/0	Ь
CAR	-(6)		30. Name and address of person who completed cause of death (Item 23a) (Type,				
)	6		SURESHKUMAR MUTTATH, 4203 QU 31. Date filed (Month, Day, Year) 32. Registrar's Signature	JEENSBURY RD	19XV	TTSVILLE,	MD 20781
	Sta Registr		ner 1 2 2006 Acres Signature	U			

State of Maryland / Department of Health and Mental Hygien 👂 🕦 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Johnnye M. Spires December 6 2006 9:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Yrs. Director 264-20-2008 92 June 27, 1914 Florida Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23a or 28e-f show empiriquey or other traumatic event, if a Medical Evanination must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland | Prince George's Bowie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20715 13220 Idlewild Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 21 No If Yes, Give 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced ear or Dates: <u>American</u> Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Department of Navy Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Wood 2 Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Fields/Granddaughter 14838 London Lane, Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other precent 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) 12/14/2006 Suitland, MD Washington National 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 5 Benning Rd., Wash., 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resolution heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition **Physician** /Medical resulting in death) Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence Examine the Hospital or Attending Physicien: The law requires that the death certificate be executed the attending physicien and thed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown þ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed 2 🗆 No 3 ☐ Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed this certificate 2 2 No 1 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ္ 1 Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 State Registrar

			1 - For State Registrar	State of Maryla			nt of He <i>te of E</i>		Mental Hy	/giene () {	96	41403
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of D Month	Day	Year	3. Time of Death
	/Media	al	Beulah Bell	Sampson			-			ber 8, 2	006	1:40 a M
7	Examir	er	4a. Facility Name (If not institution, giv. St. Mary's Nurs			4b. Cir		Location of Dea	th	4c. County		1
7%	Funeral	7	5. Social Security Number 6. S		s. last birthday)	If Und	er 1 Year	ardtown If Under 24 Hrs		rth	Mary 9. Birtho	
	Director	7	578-01-7731	□ M 280 F 101	Yrs.	Months	Days	Hours Min	. (Month, D	ay, Year) 0, 1905		lace (State or Foreign htry) Sinia
	pu 🟃		Usual Residence of Decedent 10a. State 10b. County	100.0	See Town and							
	shov ed ed	2			City, Town or Lo						1	0d. Inside City Limits 1 Yes 2 No
	28a-f	Director	Maryland St. Mar 10e. Street and Number	ry's I	eonardi		ip Code			10g. Citizen of V	A/hat Caus	
	3a or		21585 Peabody St	root		101. 2		-2955		U.S.		itt y r
	death ms 2	Funerai	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Dec			Specify Yes or N rto Rican, etc.)	o- 14. Rac	e - Americ	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show says injury or other treumatic event, The Medical Examinar must be notified at once.	by Fu	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1		ecify Cuban 2⊠ No	, Mexican, Puei Specify:	rto Rican, etc.)	Specify	ck, White, v: Whd	
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Maryland	De fi	Be	17. Father's Name (First, Middle, Last)							, Maiden Suman	•	
7	should nd Me mark matic	은	Hugh B. Sampso		19h Mailir	og Addres	s (Straat ar		-	Rippeto		Code
	ith ar 27 ts r treu		David Sampson, J							nicsvill		
ē,	S 1 ar		20a. Method of Disposition	20b.	Place of Dispo	sition (Na	ime of	1	Date	20c. Location -		
Ë	Page nent o nt: If iry or		1 Burial 2 Cremation 3 ☐ 4 Donation 5 Dother (Specifi		rt Linco			1	12/2006	Brentwo	ood.	Maryland
Baltimore,	permit. Depertrimporte eny inju		21. Signature of Funeral Service Licen		11100					uneral H	-	•
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			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one cause on each line					-			Approximate Interval Between
hia	Physician		Immediate Cause (Final disease or condition resulting in death)	a Cardio) res	1q e	rati	ory	fai	ure		Onset and Death
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	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Del	1400	a ti	ON					
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_	- CD es	/Me	IF FEMALE:	23c. If yes, outcome of pregr	Janou .							
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ď.	The law requires that the death certifite has been signed by the attending bage 2 should be detached for use a	by P	Part II. Other significant conditions of	ontributing to death but not re	sulting in the ur	nderlying	cause given	in Part I.	23e. Did	obacco use contr	ribute to th	e cause of death?
ğ	w require been sig should b	led t							1 🗆	Yes 2□No	3 🔲 Prob	ably 4 Unknown
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<u>~</u>		Con							perfo	rmed?	leath?	2 No
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1	7		· AY	Shah			D	4706	6	12.		
	(2)		30. Name and address of person who o					D. Shal				
	2		22650 Cedar La			n, M	2065	50				
	Sta Registra		31. Date filed-(Month, Day, Year)	32. Registrar's Sign	opera							

			For State Registrar	State	of Maryla		artmen rtificat			nd Mer			06	41404
riy.			Decedent's Name (First, Midd	dle, Last)					, , ,	2.	Date of Dea	Reg. No."		3. Time of Death
	Physic		Merle T.	Springhor	2						Month ecembe	Day 2r 4	Year	
Y	/Medi Examir		4a. Facility Name (If not institution				4b. City,	Town, or	Location of D		ecembe		2006 nty of Death	9:12 A ^M
			Fox Chase R	ehab. & Ni	irsing H	Home		S	ilver	Spri	no		Monto	gomery
ε.,	Funeral		5. Social Security Number	6. Sex 1X M 2□ F		. last birthday)	If Under Months	1 Year	If Under 24	Hrs. 8.	Date of Birth (Month, Day	Vearl		place (State or Foreign intry)
	Director		324-14-7393	1.6JM 2LJF	8	39 Yrs.	MOTILIS	Days	Hours			1917	7 I11	inois
	and	}	Usual Residence of Decedent 10a. State 10b. Count	v	10c C	ity, Town or Lo	cation							404 1-14 00 11 0
	Aaryl f sho	5		,		.,, , , , , , , , , , , , , , , , , , ,	oution							10d. Inside City Limits 1 XYes 2 No
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	3a or	0		. Capitol	C+ MI	J #5/.10	101. 210	Code	2001	1		10g. Citizen o		•
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pu	A d a 6	Be	17. Father's Name (First, Middle	· ·					18. Mother's	Name (Fir	st, Middle, i	Maiden Suma	ame)	
<u>ya</u>		T _o		Fred Spr	ingborn							e Reic		
Maryland	C1 40 = 0		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	g Address	(Street ar	nd Number o	r Rural Ro	ute Number	, City or Tow	n, State, Zij	Code)
	s 1 and 2 f Health item 27 i		Merle Sprin	born/Self		3700 Place of Dispos	.V.C	Capit	tol St		#5,4	18, Wa	sh.,	DC 20011
סר			1 🔀 Burial 2 ☐ Cremation		State	cemetery, crem	natory or of	ther place	1	Date		20c. Location	n - City or To	own, State
Baltimore,	it. Partmer		4 □ Donation 5 □ Other (3		Ros	ewood M								Beach, VA
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5	ding Physician: The n. n. After this certificate ha funeral director, page	2	1 ☐ Yes 2 ☐ No			ER/Outpatient	3[] DO/	A Other:	4 Nursin	g Home	5 🗌 Reside	nce 6 Ot	her (Specify	()
n C	ding F	ou	27. Manner of Death 1X□Natural 5 □ Pendir	.9	of Injury th, Day Year)	28b. Time of Injury		Bc. Injury a Work?	t			w injury occu		
Sic	Attending Physician: r death. sector: After this certific. by the funeral director.	cat	2 Accident investi 3 Suicide 6 Could	not be			М		s 2 No					
Division of Vital Records,	후흡분드	Certification;	4 Homicide determ	ined 286. Place	of Injury - At ho ing, etc. (Specif	ome, farm, stre y)	et, factory,	office		28f. L	ocation (Str City or Town	eet and Num. , State)	ber or Rura	l Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled		29a. Certifier 1 TCertifvir	ng Physician: To the	hast of my kee	wledge death	occurred -	t the t	date and a		un to the			
	24 h a Fur letely	Medical	(Check only 2 Medical one)	Examiner. Of the Da	asis of examina ner stated.	tion and/or inve	estigation,	in my opin	lion, death o	ace, and di ccurred at	ue to the ca the time, da	use(s) and m ite and place,	anner as st and due to	ated. the cause(s)
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			· 11	D L	2 6	/,	1	D52	261			Decemb		
0	(8)		30. Name and address of person		se of death (Item	1 23a) (Type, P	rint)						/ 9	
	9		Alan R.			7 Hugo	Circl	Le, S	ilver	Sprin	ng, MI	2090	06	
old i	Sta Registra		31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	tur								
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			1 - For State Registrar	State of Maryl	land / Depa			lental Hygie		41405
	Physic	ion	1. Decedent's Name (First, Middle, Las	t)				Date of Death Month	Day Year	3. Time of Death
	/Medi		LUCILLE	SHORTER				DECEMBE		10:00 A ^M
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of Death	
			PRINCE GEORGE'S				ERLY		PRINCE (GEORGE'S
	Funeral Director		5. Social Security Number 6. Se 579-34-9127	7. Age (In 80	yrs. last birthday) Yrs.	Months Day		8. Date of Birth (Month, Day, Y MAY 28 1	9. Birth Co. 926 MAR	pplace (State or Foreign untry) (LAND
	P		Usual Residence of Decedent							
	r 28a-f ehow	tor	10a. State 10b. County MD PRINCE GE		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23s or 28s-f ehow Imast te nodified at	Funeral Director	10e. Street and Number 1208 NORTHERN LIC	HTS DRIVE		10f. Zip Code	20774	10g	. Citizen of What Co	untry?
	ns 23	era	11. Marital Status	12. Was Decedent Ever	in U.S. 13.1			acify Yes or No-	14. Race - Amer	ican Indian
920	or Ite	by	1 ☐ Never Married 2 ☐ Married 3 ☐ ∰Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates:	1	fYes, specify Cu 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Sp. ban, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
15-0036	n 72	Completed	15. Decedent's Ed (Specify only highest grad	le completed)	16a. Deced	dent's Usual Occi kind of work don DO NOT use retir	upation e during most of work: red)	ing 16	b. Kind of Business/I	ndustry
2121	with lene.	mo	Elementary/Secondary (0-12) 8th	College (1-4or 5+)		E MAKER	50)		PRIVATE	
land 2	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than any injury or other treumatic event, Ira M page.	To Be C	17. Father's Name (First, Middle, Last) JAMES ENNIS					e (First, Middle, Ma. Y ENNIS	den Sumame)	
Maryland	nd 2 shou alth and M 27 is mar ir treumat		19a. Informant's Name/Relationship (T KIMBERLY A. LASS)		19b. Mailir 1208	ng Address (Stree NORTHER	et and Number or Rura RN LIGHTS I	al Route Number, C DRIVE UPP	ity or Town, State, Zi ER MARLBOT	p Code) RO, MARYLAND 20774
Baltimore,	Pages 1 a ent of Hea nt: if Itam ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	b. Place of Dispo cemetery, crem HARMONY	natory or other pl	ace)		. Location - City or T	own, State
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licens		22	. Name and Add		. B. JENK	INS FUNER	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compositors, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to in mediate.	a	se	er the mode of dy	ring, such as cardiac o	or respiratory arrest		Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):	Diese	recto	7		-11d/2
P.O. Box 6	res that the death certific signed by the attending pi be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnand Other (specify)	cy		23d. Date of deliv Month	ery Day Year
	ires tha signed t I be det	Ď	Part II. Other significant conditions co	ntributing to death but not	resulting in the ur	nderlying cause g	iven in Part I.		co use contribute to	
Ö	w require been si should	etec	15	-uan	Trion	000	0	1 Tes	21 NO 3 PIO	bably 4 Dunknown
Records,	sician: The law certificate hes t irector, page 2 s	Completed	Round	moren	1/1/	aver		24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of
Vital	an: rtifica	Bec	25. Was case referred to medical	a or	en	0	26. Place of Death	Check only one	No 1 ☐ Yes	24-3 NO
>	Physician: rthis certifica ral director, i	To E	examiner?	lospital: 1 Inpatient 2	ER/Outpatien	3 DOA 0			6 ☐Other (Speci	6()
Jοt	ding Ph h. After th funeral		27. Many r of Death	28a. Date of Injury (Month, Day Year		28c. Inju		28d. Describe how		y /
<u>.</u>	ath. Pr: Af	atic	1 Accident 5 Pending investigation	(Month, Day 1 our	/ Inquity		Yes 2 □No			
Division	tal or Atte s after de al Directo ad in by th	Certification;	4 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spi	t home, farm, streecify)	eet, factory, office	, 2	28f. Location (Stree City or Town, S	t and Number or Run tate)	al Route Number,
	To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the trestigation, in my	ime, date and place, a opinion, death occurre	and due to the caused at the time, date	e(s) and manner as s and place, and due t	tated. o the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier	2	- 0	29c. Licen	se number	29d.	Date signed (Month,	Day, Year)
R	(2)		30. Name and address of person who co	ompleted cause of death (I	Ilem 23a) (Type, I	Print)	Chever	/	45/0	6
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	90SDIFA.	LUR	CHRICKI	ymb	2078)

			For State	State of Ma	aryland		ırtment <i>tificate</i>			and M	lental Hy	/giene	200	16 1.11.0
		-	Registrar 1. Decedent's Name (First, Middle, La	net)		Cer	IIIICate	OIL	Jeam		2. Date of D	Reg. No.		2 Time of Dooth
	Physic	ian		ESKER							Month	Day		
97	/Medi		4a. Facility Name (If not institution, give			T	4b. City, T	own or	Location	of Death	12-		County of De	
To a	Exami	ier	SM AC	o stroct and numbery			-		JTON			40.	Prin	45
	Funeral		5. Social Security Number 6.		e (In yrs. la	ast birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Bi	irth		3
н	Director		216-16-4978	1 ∏ M 2 □ F	83	Yrs.	Months	Days	Hours	Min.	Feb.6	, 1 ^{Year}	3 Ma	sirthplace (State or Foreigr Country) ryland
	P		Usual Residence of Decedent											
	arylar show d at	_	10a. State 10b. County Ar	nne	10c. City,	, Town or Loc	cation							10d. Inside City Limits
	Ba-f	octo	Maryland Arur	nde1			Lot		n					1 ☐ Yes 2X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10e. Street and Number 5181 Sands F	Road			10f. Zip (207	11				zen of What (SA	Country?
	r dea	nel	11. Marital Status	12. Was Decedent E Armed Forces?	er in U.S	S. 13, V	Vas Decede	ent of His	spanic Ori n. Mexicar	gin? (Sp	ecify Yes or Ne Rican, etc.)	0-	14. Race - An Black, Wh	nerican Indian,
36	s afte or if	Y F	1 ☐ Never Married 2 💢 Married	1 ☐ Yes 2√√N If Yes, Give	lo		□Yes 2		Specify:		, , , , , , , , ,		Specify: B	
ö	hour: :ural' al Ex	d b	3 Widowed 4 Divorced	Year or Dates:		10 5								
15-	n 72 "nat	lete	15. Decedent's E (Specify only highest gr	ade completed)	- ()	16a. Deced (Give I	ent's Usuai kind of work OO NOT use	Occupa done d	ition <i>uring mos</i>	t of work	ing	16b. Kii	nd of Busines	ss/Industry
21215-0036	filed within Hygiene. Ither than "	E C	Elementary/Secondary (0-12)	College (1-4or 5-	+)		Bui					Co	nstru	ction Co.
9	filed Hygi sther ent, t	Ö	17. Father's Name (First, Middle, Last	')		110 1110				er's Name	(First, Middle			ction co.
an	ld be ental ked c	To Be	Edward		Ses	ker			Sar		E11e		Se1mo	n
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street a	nd Numbe	er or Rur	al Route Numb	ber, City o	r Town. State	. Zip Code)
Ž	and 2 lealth a m 27 Is		Beverly Sesker	/Daughte	r									ro,MD20772
ē,	es 1 a of Heg		20a. Method of Disposition		20b. Pla	ace of Dispos emetery, crem					Date			or Town, State
E	Page lent c nt: If ry or		1 ★Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Res	urrec	tion	Ce	m. 1	2/1	2/06	C1i	nton,	MD
Baltimore,	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Lice			22.	Name and	Addres	s of Facilit	y Se	we11 1			
m	permi Depa Impo any ir		Blady a.	Senell		14	51 D	are	s Be	ach	Řđ.Pi	rinc	e Fre	ome d.,MD20678
	TEXTS.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.	. Do not ente	r the mode	of dying	g, such as	cardiac o	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Sis									Onset and Death
	/Medical		resulting in death)	a. Due to (or as a		ence of):	0	- 4						5 200
Ε	Examiner		Sequentially list conditions	b UTT	nary	tract	M	cho	20					3 day
	p #	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	riconseque		E.			Λ Λ	ailms	,		1
	ficate be executed physician and sthe burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Dehy	diahi		zcute		renou	<u> </u>	airma			
30,	oe exi	<u> </u>	resulting in death) East	Due to (or as a	conseque			())						
68760,	cate b	dica		d Chage	IV	Lelon	can	un						
			IF FEMALE:	00- 16										
Вох	death certifi attending I I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p	2 🗆 Fetal	death 3□	Ectopic pre					2	3d. Date of d Month	elivery Day Year
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	ath 5⊔	Other (spe	c <i>ity)</i>						Day 10a
P.0	that the de	Ph	Part II. Other significant conditions	contributing to death bu	t not resul	ting in the un	derlving cau	use give	n in Part i		23e. Did	tobacco us	se contribute	to the cause of death?
or Vital Records,	% F 0	d by	-	ū		ŭ	, ,	3					_No 3□I	A
Ö	w require been signature	Completed											_	
Re	has ge 2	臣									24a. Was		24b. Were a prior to death?	autopsy findings available completion of cause of
<u>a</u>			05.11								1□ Yes	2 No	1 Ye	
Ξ		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		200		Otho	p.		(Check only o			
	ਦ = E	<u>ا :</u> ا	27. Manner of Death	28a. Date of Injury		R/Outpatient 28b. Time of		,	4 ⊔ Nu		ne 5□Resi 28d. Describe			ecify)
on	nding th. : After s funer	tiol	1 √ Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	м	c. Injury Work: 1 □ Y	? ′es 2		200.150	now injury	Occurred	
Division	or Attending after death. Director: After in by the funer	Certification:	3 Suicide 6 Could not b	e 28e. Place of injur			et, factory,				28f. Location (Street and	d Number or F	Rural Route Number,
Ö	ੂ ਵੇ ਫ	erti	4 Homicide determined	building, etc.	. (Specify)						City or To			
	ospit. hours inera y fille		29a. Certifier 1 Certifying Pt	nysician: To the best o	f my know	ledge, death	occurred at	t the time	e, date an	d place,	and due to the	cause(s)	and manner	as stated.
	To the Hospital within 24 hours a To the Funeral c completely filled	Medical	(Check only 2 Medical Examone)	miner: On the basis of and manner stat	examination	on and/or inv	estigation, i	n my op	inion, dea	th occurr	ed at the time,	, date and	place, and di	ue to the cause(s)
	To ti withi To ti comp	ž	29b. Signature and title of certifier				29c.		number					nth, Day, Year)
			V.lamari-	MP				Do	063	18 3	>	13	2/06/0) だ
			30. Name and address of person who	completed cause of de	ath (Item 2	23a) (Type, P	Print)							

4

State Registrar VIJAY

31. Date filed (Month, Day, Year)

SHRI

DHMH 17 Rev 1/2001

5703

32. Registres Signature

KANNAN

8 2006 >

SURRAITS

ROAD

CLINTON

. MD

20735

		1 - For State Registra/WEND#5perIN		of Marylan		artment rtificate			and Me	ental H	ygiene Reg. No	/ 11	J 6	41407
Physic		Decedent's Name (First, Middle, Betty Louise K	Last)							2. Date of D Month Dec	Da		Year	3. Time of Death 7:25 A M
/Med Exam		4a. Facility Name (If not institution, Doctor's Hospi	give street and n				ham				-	.County	of Death Geor	ge's
Funera Directo		578-30-6250	3. Sex 1 ☐ M 2X F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Months	Year Days	Hours	Min	8. Date of E (Month, I Sept.	Day Year)	1926	Coun	ace (State or Foreign try) :h Carolina
Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County D • C • N/A			y, Town or Lo								10	0d. Inside City Limits 1 X Yes 2 □ No
with the	i Direc	10e. Street and Number 4623 8th Street	N.W.			10f. Zip (/hat Count	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at any one in	d by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Dec Armed F ad 1 Tyes If Yes, G Year or	2€ No ive		Was Decede	ent of His fy Cuban	Specify:	gin? (Spec , Puerto F	cify Yes or Nican, etc.)	No-	14. Race Black Specify: Afric	e - America k, White, e	an Indian, atc. American
within 72 tiene.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done du retired)	ıring most		g			siness/Ind	•
uld be filed Aental Hygirked other tic event,	To Be C	17. Father's Name (First, Middle, L Anthony C. Kir				- 6,7		18. Mother	r's Name	(First, Midd	le, Maiden			
in and 2 should the and in the alth and in the 27 le mail other treums.		19a. Informant's Name/Relationsh Twanna Wiggins 20a. Method of Disposition	p (Type, Print) (daugh			Ross esition (Name	Stre	et,	Bowie		207	20	State, Zip	
partill Dages Department of Important: If i any injury or or or or or or or or or or or or or		1 🔀 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L	ecity)	1 31810	cust G		Bapt. Address	of Facility		ire Fu	nera:	1 Se		
Physician / Medica Examine physician and physician and physician and the prinal-transit	Le	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Co	rdiac An for as a conseq ronary A for as a conseq tastatio	Artery uence of): Lung									3 years
To the Hoepitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐Live	utcome of pregna birth 2 Feta nant at time of d	Ideath 3	Ectopic pre Other (spe						23d. Date Mon	of delive	ry Day Year
quires that n signed build be deta	þ	Part II. Other significant condition	s contributing to	death but not res	ulting in the u	nderlying ca	use giver	n in Part I.						e cause of death?
The law requirate has been single 2 should	Completed									per	as an opsy formed?	d	rior to con eath?	osy findings available apletion of cause of 2 No
vician: The sectificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA	Other			Check only		6 □Othe	or (Specific	,)
ending Physician: The sath. or: After this certificate he the funeral director, page	ertification; T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigs	28a. Date (Mo.	of Injury nth, Day Year)	28b. Time o		c. Injury		21	Bd. Describe				,
To the Hoepitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	O	3 Suicide 6 Could not determine	ned 286. Plac build	e of Injury - At he ding, etc. (Specif	^{(y})					City or T	own, State	a) 		Route Number,
To the Hospital or within 24 hours afte To the Funeral Dii	Medical	(Check only 2 Medical E	Physicien: To the xaminer: On the and ma			vestigation, i	in my opi	nion, deat			e, date and	d place, a	nd due to	the cause(s)
10	-	29b. Signature and title of certifier	9.1	West	TO		License						8 , 2	2006
		John E. McKnig	ht, M.D.	1150 V	arnum	Street	t, N	.E.	Wash	ingto	n, D.	С.	20017	7
S Regis	tate trar	31. Date filed (Month, Day, Year) DEC 1 2	2006	egistrar's Signa	ture	mente								

			1 - For State Registrar	State of Maryland		nt of Health and te of Death	Mental Hygie	/ 11115	41408
-	Physic /Medi		Decedent's Name (First, Middle, Last, NAS RO LLAH	,	RT - KER	MANI	2. Date of Death Month DECEMBE	Day 08 2006	3. Time of Death 3. Time of Death
	Examin Funeral Director	ner	619-66-6227	VENTIST HO	SPITAL /	Town, or Location of Dea	8. Date of Birth		
	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Md. Montgome	· · · · · · · · · · · · · · · · · · ·	nestown				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28	al Director	10e. Street and Number 14416 Weathered	l Barn Court		ip Code 20874		. Citizen of What Cou	ntry?
9036	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any njury or other traumatic event, tra Medical Exercities must be redited at 2006.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 2X No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	
Maryland 21215-0036	d within 72 ho giene. Ir than "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of w life. DO NOT unemplo	ork done during most of wa use retired)	rking 16	b. Kind of Business/In	ndustry
ryland	should be file and Mental Hyg s marked othe umatic svent,	To Be C	17. Father's Name (First, Middle, Last) Mohammad Sama 19a. Informant's Name/Relationship (Ty	ari-Kermani	10h Mailing Addro	18. Mother's Na Fateme s (Street and Number or R		i-Kerman	
ore, Ma	ges 1 and 2 s t of Health an If itsm 27 is or other trsu		Ben Samari / sc 20a. Method of Disposition 1 X Burial 2 Cremation 3 P	20b. Pla Removal from State	14416 W ace of Disposition (Nametery, crematory or	eathered Ba	Date 200	Darnest c. Location - City or To	own, State
Baltimore,	permit. Pac Department Important: any injury		4 Donation 5 Other (Specify) 21. Sign our of Funeral Service up no	Pa	22. Name a	emetery 12, nd Address of Facility (Kennedy St.	Jniversal	Mortuar	У
	Physician /Medical Examiner		23a. Part1. Enter the disease, of complishock, or hear failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. RESPLA Due to (or as a consequence ASPLRA	RATORY ence af): TION				Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed sie has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	dicai Examiner	Social desiration of the second of the secon	Due to (or as a consequence. Due to (or as a consequence.	·				
P.O. Box 6	the death certific y the ettending p iched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of time of deserting the control of the co	death 3 ☐ Ectopic p			23d. Date of delive Month	ery Day Year
rds, P	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions cor			cause given in Part I. PLegia	23e. Did tobac	co use contribute to the	./
Division of Vital Records,	: The law receive hes bear cete hes bear page 2 sho	Completed	DIABETES	MELLIT		YPE 2	24a. Was an autopsy performed 1 Yes 2	1? phor to co	opsy findings available impletion of cause of
<u> </u>	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Other	ath Check only one)		
on of	Attending Physician: r death. sctor: After this certifice by the funeral director, i	ition: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1	ER/Outpatient 3 D 28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	dome 5 Residence 28d. Describe how i		ý)
Divis	205-0	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	me, farm, street, factor	y, office	28f. Location (Stree City or Town, S	t and Number or Rura itate)	al Route Number,
	To the Hospital of within 24 hours af To the Funers! D completely filled is	edicai	one)	sician: To the best of my know ner: On the basis of examination and manner stated.	viedge, death occurred on and/or investigation	at the time, date and place n, in my opinion, death occu	a, and due to the caus arred at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
)	T V With	Σ		ISION MEH	IARI	c. License number D 64478		Date signed (Month,	08, 2006
			30. Name and address of person who co Fisehatsian 31. Date filed (Month, Day, Year)	Mehari	9901 M	IEDICAL CE	NTER DR	IVE ROCK	cuille, MD
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	H Lead	,			

	For Stete Registrar	State of Maryla	nd / Depa	artment o	of Health and of Death	Mental H	ygiene	006	1:1409
	1. Decedent's Name (First, Middle, L	ast)				2. Date of D	Death Day	Year	3. Time of Death
Physician /Medical	Fra	nklin Burleigh	Stout				ber 18	, 2006	1922 P
Examiner	4a. Facility Name (If not institution, ga				wn, or Location of Dea	ith		unty of Death	
	223 Nellies Co		to a disability	Risi	ng Sun			ecil_	
rector	5. Social Security Number 6. 220-42-9830 Usual Residence of Decedent	Sex 7. Age (In yrs 1∭X M 2□F 62	Yrs.		Pays Hours Mir	s. 8. Date of E (Month, DEC 14	Day, Year)	4 West	place (State or Foreig ntry) Virginia
MO 11	10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limit
jo jo	Maryland Cecil		Rising	Sun					1 ☐ Yes 2 🛣 N
ust be notified at	10e. Street and Number			10f. Zip Co	ode		10g. Citizer	n of What Cou	ntry?
alD	223 Nellies Co	rner Road		219	11		Uni	ted Sta	ates
other treumetic event, the Medical Exarching resist To Be Completed by Funeral	11. Marital Status	12. Was Decedent Ever in the Armed Forces? 196	J.S. 13.1	Was Decedent	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No Rican, etc.)	No- 14.	Race - Ameri Black, White	
by Fu	1 ☐ Never Married 2X Married	1 VYes 2 Not 90 If Yes, Give Year or Dates: 196		1 ☐ Yes 2 🔯		, ,		oecify:	
q p	3 Widowed 4 Divorced							WI	nite
r, tre Madeal	15. Decedent's I (Specify only highest g	ade completed)	(Give	dent's Usual O kind of work a DO NOT use n	occupation done during most of wi retired)	orking	16b. Kind	of Business/Ir	ndustry
d Lo	Elementary/Secondary (0-12)	College (1-4or 5+)		ectrici			Co	rporate	P
e C	17. Father's Name (First, Middle, Las	t)	21(5001101		ame (First, Midd			
To Be	Dewey Stout				Pau1	ine Ham	pton		
	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (St	treet and Number or F	iura/ Route Num	ber, City or To	own, State, Zij	o Code)
er tre	Elizabeth M. S	tout/Wife	223 N	Vellies	Corner Ro	ad. Ris	ing Su	n Mar	land 2191
Otto	20a. Method of Disposition	20b.	Place of Diene	cition /Alama	of I	Date ember		tion - City or T	
5	1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Imm	cemetery, crer naculat netery	e Conce		2006	Cherr	v Hill	, Maryland
any injury or of <u>once</u> .	21. Signature of Funeral Service Lice		Hi	Name and A	ddress of Facility me for Fur tockton St				
	23a. Part I Enter the disease, or cor shoo, or heart failure. List only	polications that caused the dea	ith. Do not ent	er the mode of	f dving, such as cardia	reet, E	Arrest.	Maryla	Approximate Interval Between
-1					ANCER				Interval Between Onset and Death
cian Iical	Immediate Cause (Final disease or condition resulting in death)	a Due to (or as a conse		-K L	ANCER				
iner		Due to (or as a conse	querice oi).						
e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	quence of):					-	
直	Cause (Disease or injury that initiated events	C							
Exa	resulting in death) Last	Due to (or as a conse	quence of):						
edical Examine		d							
clan/Medi	IF FEMALE:								
lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐Live birth 2☐Fet	al death 3 □	Ectopic pregn			23d	. Date of deliv Month	ery Day Year
detached for use a property of the policy of	1 Yes 2 No	4☐Pregnant at time of 9☐Unknown	death 5□	Other (specif	fy)			Wichtin	Day Tour
Phy	Part II. Dther significent conditions	contributing to death but not re-	culting in the u	ndarh/ina cauc	en given in Part I	23a Did	tobacco use	contribute to t	he cause of death?
D	arth, ballot digililioont contaitons	outhbuting to doubt but not to	sailing in the di	idenying caus	o giveri ili raiti.]Yes 2□N		pably 4 MUnknowr
leted by Pi									
1 0						24a. Wa aut	s an 2 opsy formed?	4b. Were auto prior to co death?	ppsy findings available impletion of cause of
Com						1 ☐ Yes		1 ☐ Yes	2 No
Be	25. Was case referred to medical examiner?	Hospital:			Othor	eath (Check only			
ral dir	1 Yes 2 No	1 Inpatient 2	28b. Time of		4 🗆 Nursing	Home 5 🔀 Res		, , , , , , ,	(y)
Certification:	1 Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Year)	Injury		Injury at Work? 1 Yes 2 No	2041 2000114		551104	
fica	3 ☐ Suicide 6 ☐ Could not	28e. Place of Injury - At h	nome, farm, str			28f. Location	(Street and N	lumber or Rura	al Route Number,
erti	4 Homicide determine	building, etc. (Speci	ify)	,,		City or To	own, State)		
completely filled in by the funeral director, Medical Certification; To Be (29a. Certifier 1★ Certifying P (Check only one)	hysician: To the best of my kn miner: On the basis of examinated and manner stated.	owledge, death	occurred at the	he time, date and place my opinion, death occ	e, and due to the curred at the time	e cause(s) and e, date and pla	d manner as s	tated. o the cause(s)
completely filled in by	29b. Signature and title of certifie			29c. Li	cense number		29d. Date s	igned (Month,	Dav. Year)
3	//			1	0000805	7	,	20/06	
N	7		00. \ T			t	10-1	1 - 6	*
20	30. Name and address of person who			,	D. C.	0100	,	D =	40-40
Class	Kathir Suppiah, M	I.D., 4701 Ugle 32. Registrar's Sign	town-St	anton	Rd., Suite	2100, 1	Wewark,	Delaw	are 19713
State legistrar	DEC 9.7	7		Cast ?					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene (For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 11, DEC. 2006 0615 JOANN POWERS SMITH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ALLEGANY CUMBERLAND WMHS - MEMORIAL CAMPUS 8. Date of Birth (Month, Day, Year) Dec. 11,1930 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 X F 174-34-7869 76 Yrs. Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "naturel", or itema 23a or 28a-f ehow traumatic event, the Modical Examinar must be notified at Artemas Bedford 1 ☐ Yes ② No PA Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 17211 U.S.A. 1305 Purcell Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛱 No Specify: þ 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clothing Manufacturer Presser permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any njury or other traumatic event, 906.6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Goldamae Frances Smith Fred M. Powers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca J. Smith / Daughter 1305 Purcell Road, Artemas, PA 17211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Altoona Area Crematory12/12/2006 Altoona, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dalla Valle Funeral Service, P.O. Box 179, Everett, PA 1 Inc. Worwich THUILL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardiogenic Shock week /Medical Due to (or as a consequence of): Examiner ardionyonathy Lischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): to the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit oronar Due to (or as a consequer ce of) Division of Vital Records, P.O. Box 68760 ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached Physi 9 Unknown 9 Dunknowh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ dermatiti 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient P 1 ☐ Yes 2 ☐ No 3□ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19318 December 11, 2006 an use of death (Item 23a) (Type, Print) Road Cumberland, MD Oldtown M.D . 517 man 31. Date filed (Month, Day, Year)
DEC 1 2 2006 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryl.	and / Depa		lealth and M	ental Hygi	_		Polarous de la constante de la	-
	Dhuaisi		1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day	Year	3. Time of D	Death
	Physici: /Medic	-	CLARA MAY SP	ENCER		Ţ	DECEMBER	14	2006	1030	М
	Examin		4a. Facility Name (If not institution, give street and number)			Location of Death			y of Death		
) S	Đ.	MEMORIAL HOSPITAL		CUMBERI			ALL	EGANY		
	Funeral		1□M 217 F	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Coun	* /	Foreign
c.	Director		235–52–7446 Usual Residence of Decedent	7.5			DEC. 12,	1911	MAR	YLAND	
	yland now at		10a. State 10b. County 10c.	City, Town or Lo	cation				1	0d. Inside City	
	e Mar a-fsk iified	ctor	WV MINERAL	RIDGELE	Y					1 ☐ Yes	2 ⋉ No
	or 28 e not	Director	10e. Street and Number		10f. Zip Code	-	10	g. Citizen of	What Coun	try?	
	ath w	ra	42 KNOBLEY STREET		26753			U.S.			
	er de items ner m	Funeral	11. Marital Status 12. Was Decedent Ever i Armed Forces?	n U.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)		ce - Americ ick, White,		
20	rs aft I", or xamil	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 □ Yes 21 No	Specify:		Speci	fy: WIH	ITE	
3	2 hou atura cal E		15. Decedent's Education		dent's Usual Occup		1	6b. Kind of E			
<u> </u>	hin 73 In "n Media	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	kind of work done of NOT use retired	during most of workir d)	ng				
21215-0036	er tha	20I	7	REC	CORDER		TC.	WN OF	RIDG	ELEY, V	VV_
	uid be filed within 72 hours after death with the Maryland Mental Hygiene. Arked other than "natural", or items 23a or 28a-f show atic event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M.	aiden Surna	me)		
<u> </u>	2 should be filed and Mental Hygi is marked other raumatic event, t	ပ္	ALONZA ISAAC CHANEY	T		NETTIE	TWIGG				
Maryland			19a. Informant's Name/Relationship (Type. Print)			and Number or Rura				Code)	
ກ໌ ອ້	of Health item 27		WANDA ZOLLNER / DAUGHTER 20a. Method of Disposition 20	b. Place of Dispo	sition (Name of	322, RIDG				wn. State	
9	Pages nent of I ant: If ite ary or o		1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	natory or other plac						
	permit. Pages Department of Important: If i any injury or one		4 □ Donation 5 □ Other (Specify) 21. Signaturs of Funeral Service Licensees		MEML • PA 2. Name and Addres	ARK 12/17/ ss of Facility	/2006	CUME	ERLAN	D, MD	
Ď	permit. Departm Importa any inju		Hends A. Lixhuch)	UPCHURCE	I FUNERAL	HOME, P.	.A.	MD	21502	
н	3		23a. Part1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.		er the mode of dyin	g, such as cardiac o	r respiratory arres	KLAND, st,	MD	Approximate	1000
	Physician					OPATH)			Î	Onset and D	eath
A 3.	/Medical		resulting in death) Due to (or as a con		1-2 (011.7	0 / / (1 /)	/			771 (01	· UW
	Examiner		Sequentially list conditions b.								
ы	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	sequence of):					26753 Location - City or Town, State CUMBERI, AND, MD		
	ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events c	coaucaso of):							
,00,	be ex cian burial	cal E	Due to (of as a con	sequence or).							
α	physi physi the l		d								
BOX 68	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medi	IF FEMALE: 23c. If yes, outcome pf pre	egnancy				23d D:	ate of delive	·rv	
ñ	atter after for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 Section 12 months? 1 Yes 2 No		Ectopic pregnancy Other (specify)	<u>'</u>					ear
л Э	the c by the	nysi	9 ☐ Unknown 9 ☐ Unknown								
r.	s that ned b e deta	by P	Part II. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	acco use con	tribute to th	e cause of de	ath?
ğ	equire en sig ruld b	pa pa	HYPERKALEMIA				1 ☐ Yes	2 □ No	3 ☐ Prob	ably 4∭Uı	nknown
ပ္ပ	aw re is be	Completed					24a. Was an autopsy	24b.	Were auto	psy findings a	vailable
Ť	The ate has page	mo.					perform	ed? No	death? 1 ☐ Yes		000 01
<u> </u>	cian: ertific	Be (25. Was case referred to medical examiner?			26. Place of Death		-			
	hysio this c	2	1 ☐ Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien		4 LI Nursing Hor	ne 5 🗆 Resider			/)	
Ë	ing F	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Yea	r) 28b. Time of Injury	Wor	k?	28d. Describe hov	v injury occu	rred		
<u>s</u>	death death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - A	At home, farm, str		Yes 2□No	28f. Location (Stre	eet and Num	her or Rura	l Route Numb	or
Division or vital Records,	after Direction by	Certification:	4 ☐ Homicide determined building, etc. (Sp	pecify)	oot, radiory, omoo		City or Town,		Der of Flata	rroate reamb	,01,
	Hospital 24 hours a Funeral I etely filled		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, deatl	h occurred at the tir	me, date and place, a	and due to the car	use(s) and m	nanner as st	ated.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or in	vestigation, in my o	ppinion, death occurr	ed at the time, da	te and place	, and due to	the cause(s)	
	To the I within 2 To the Complet	Me	29b. Signature and title of certifier	2	29c. Licens			d. Date sign			,
	6		Maral M	1	P006	3118	Î	2 -	14-	200	6
,	_		30. Name and address of person who completed cause of death	(Item 23a) (Type,		7	^	4		200 d Mi	
	MLD		Wirasat Hasnain M.D.	900	Setor	Drive	Cu	mbe	rlan	d, M	021
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's S	ignature de la companya de la compan							
Щ	negisti	ar	DL 0 1 0 2000	J. A	market 1						

Amend Item #5 State of Maryland / Department of Health and Mental Hygiene State WCHD/SH 12/21/06 per FH Certificate of De " 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1:24 PM M Virgil Josephine Settles December 14 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 16505 Virginia Ave. Williamsport Social Security Number 219–12–1778 219–12–1788 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2**V**□ F Months Days Director 84 5 - 1922Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location a or 28a-f show be notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a edical Examiner must t 16505 Virginia Ave 21795 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced If Hygiene. other than "natura rent, the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Russell E. Wachtell

19a. Informant's Name/Relationship (Type. Print) Edith Gertrude Stockslager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice D. Frey - daughter 14228 Rinehart Road Smithsburg Maryland 21783 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ortant: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any injury or once. Cedar Lawn Mem. Park 12-18-06 Hagerstown Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death The gall bladde **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed g physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ distribute lun der care 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pade 1 ☐ Yes 2 No 1∐ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and npleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER 5, LOIE ELLA SMITH 2006 13:20 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 106 MAIN STREET CHURCH HILL OUEEN ANNE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth Year O1/15/1921 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 144-16-1257 1 ☐ M 2 🛱 F 85 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be recitived a sone. OUEEN ANNE'S Y☐Yes 2 No Director CHURCH HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 MAIN STREET 21623 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: WHITE Specify þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NEAL DAVIDSON ETTA SCUDDER ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRI SANDERSON/GRANDDAUGHTER 211 LONGFELLOW DRIVE, CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriaf 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 12/07/2006 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complishock, or heart failure. List only disease eations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, accause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HTN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medicai 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has t page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 2 Da No 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA After this Certification: 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 PNatural 5 Pending s after death. 1 □ Yes 2 □ No investigation 2 Accident the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funeral I
completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 12/06/2006 H0662423 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6602 CHURCHITHU IZD CHESTERIOWN MO 31600 De LA 2008 MD 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar DHMH 17 Rev 1/2001

			1 - State of Maryland State of Maryland	d / Department of He Certificate of D	-	giene Reg. No. 2006	4 14 14
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) RODE(+ E SCHU 4a. Facility Name (If not institution, give street and number) Chester River Hospital (1911)	1/2 4b. City, Town, or L	2. Date of Di Month	Day Year	3. Time of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 399-07-4607 1 № M 2 ☐ F 9	O Yrs. Months Days	Hours Min. 8. Date of Bi	rth 9. Birth Con / 1916	place (State or Foreign untry) WI
	the Marylan 28a-1 ehow cuiting at	ector	1	ESTERTOWN 10f. Zip Code		10g. Citizen of What Co	10d. Inside City Limits 1√2 Yes 2 □ No
	72 hours after death with the Maryland natural', or iteme 23a or 28a-1 ehow dicel Examinat must be codified at	by Funeral Director	125 HERON POINT 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	21620	panic Origin? (Specify Yes or N , Mexican, Puerto Rican, etc.)	USA	ican Indian,
21215-0036	72 hours afte "natural", or i dical Exami	eted by F	1 Never Married 2 Married 1 Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 ☐ Yes 2 ☑ No 16a. Decedent's Usual Occupati (Give kind of work done du	Specify: ion tring most of working	Specify: WH	ITE
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Baltimore,	Page nent o ant: If ary or		1 N Burial 2 Cremation 3 Removal from State	ace of Disposition (Name of metery, crematory or other place) PAUL S CEMETER 22. Name and Address	Y 12/08/2006	20c. Location - City or T	
Ba	permit. Departr importa		> Kith of filled	FELLOWS, H 130 SPEER	ELFENBEIN AND ROAD, CHESTERT		
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or complications).	ence of):			Approximate Interval Between Onset and Death
Box 68760,	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	icai	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant 1 live birth 2 Featl	ncy		23d. Date of deli	- 7
P.O.	uires that the dea r signed by the ati Id be detached fo	d by Physician/Med	In the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resu	ath 5 ☐ Other (specify)		Month tobacco use contribute to Yes 2 Mo 3 □ Pro	Day Year the cause of death?
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۵	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical Cer	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinati and manner stated.	viedge, death occurred at the time	e, date and place, and due to the	cause(s) and manner as	stated. to the cause(s)
	within comp	Me	29b. Signatura and title of certifier		number 06 0 3 0 7	29d. Date signed (Month) 12/4/0 5270mm	Dey, Year)
	Sta Registr		30. Name and address of person who completed cause of death (Item WCGHR62 (E) MGM W 131. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) DEC 0 6 2006	S(fran (H)	STUS Class	5 Briouni	MD 2063
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			For State Registrar	State of Ma	-	artment of Hea		ental Hygiene Reg. No	711115	41415
抱	Physici	an	1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month Day		3. Time of Death
	/Medic		Gladys The Gladys The 4a. Facility Name (If not institution,			4b. City, Town, or Loca		December 4	2006 County of Death	
50,	- LAdii(iii	ei ei		ge's Hospita	1		everly_		Prince	George's
	Funeral		, , , , , , , , , , , , , , , , , , , ,	5. Sex 7. Age 1 M 2 XF	(In yrs. last birthday) Yrs.		ours Min.	B. Date of Birth (Month, Day, Year)	Coi	nplace (State or Foreign untry)
rife.	Director		578-36-6692 Usual Residence of Decedent					Mar. 4, 19	129 Wa	sh., DC
	anytan show	<u></u>	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits 1, Yes 2 No
	the M	Director	DC 10e, Street and Number	#502	North	Was	shington	10g. Cit	izen of What Cor	A
	3a or	0	5000 N. Helei				20019		United	•
	r deat	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spec exican, Puerto R	fy Yes or No- ican, etc.)	14. Race - Amer Black, White	
36	be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or items 23e or 28e-f show event, the Medical Examinar must be notified at	by Ft	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☑ Divorced	d 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:)	1 ☐ Yes 2 🎇 No Sp			Specify:	Black
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Maryland 21215-0036	Aithin 7	Completed	Elementary/Secondary (0-12)	Cottege (1-4or 5+	life.	DO NOT use retired)		'	27	
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au	fental fental rked o	To Be	Unknown					Estelle	Thomas	
lary	2 should and Men is marke		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mailii	ng Address (Street and I	Vumber or Rural	Route Number, City o	or Town, State, Z	ip Code)
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Madical Examinar must be notified at 0 ace.		Vivian Thomas, 20a. Method of Disposition	Niece Niece	20b. Place of Dispo	Stanton Ro	l., SE	#303, Wash	DC 2	0020 Town, State
OE E	Pages nent of h ant: If Ite		1 ☐ Burial 2 K Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			matory or other place) Crematory	12/19/	2006	Clinton	n. MD
Baltimore,	Departmit. I		21. Signal re of Funeral Service Li			2. Name and Address of	Facility S	tewart Fun	eral Ho	me
	20 E E O		John I.	I would				., NE Wash	., DC 2	
	LAL		23a. Part 1 Inter the disease, or c shoot, heart failure. List o	omplications that caused to the one cause on each line	ne death. Do not ent).	er the mode of dying, su	ich as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
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9	seath certifica attending pt for use as t	/Mec	IF FEMALE:	23c. If yes, outcome of	f pregnancy				23d. Date of deli	ven/
. Box	thet the death cer ed by the attendir detached for use	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	et the by the	Phys	9 ☐ Unknown Î	9□ Unknown						
	w requires thei been signed b should be det	þ	Part II. Other significant condition Respirat	ory Failure	not resulting in the u	nderlying cause given in	Part I.	1 Yes 2		the cause of death? babbly 4 Anknown
Division of Vital Records,	2 2 2	Completed	Seizure	Disorder				24a. Was an autopsy performed?	prior to death?	topsy findings available comptetion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital: , ear			Place of Death			
ot	Attending Physician: r death. ector: After this certifica by the funeral director.	: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o			e 5 Residence		cify)
<u>o</u>	ath. rr: After	atlor	1 Natural 5 Pending 2 Accident Investiga	(Month, Day	Year) Injury		2 🗆 No			
)ivis	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ertification:	3 Suicide 6 Could no 4 Homicide determin		y - At home, farm, sti (Specify)	reet, factory, office	28	If Location (Street ar City or Town, State	nd Number or Ru e)	ral Route Number,
	spital	O	29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, deat	h occurred at the time, d	ate and place, ar	d due to the cause(s) and manner as	stated.
	To the Hospital within 24 hours of To the Funeral completely filled	ledical	(Check only 2 Medical E	xaminer: On the basis of and manner stay	xamınation and/or ın	vestigation, in my opinio	n, death occurred	at the time, date and	d place, and due	to the cause(s)
	To To I	Σ	29b. Signature and fitte of certifier	11111	1	29c. License nur	mber - 73 1		te signed (Month	n, Day, Year)
Λ	(i)		30. Name and address of person w	to completed cause of dea	ath (Item 23a) (Type.		-/3/1		/ -3	/ 50.
K	0		Revathy	Murnhy 6130	Landover		rly, MD	20785		
100	Sta Registr		DEC 08 2006	Same S. Registrar	's Signature					

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aria Corrina To				giene
Discolation in the second		1- For State Certificate of L Registrar 1. Decedent's Name (First, Middle,Last)		Reg. No. 3. Time of Death
Physicia edical Examir	ner	Maria Corina Torres		Month Day Year 2310 hrs
			City, Town, or Location of Death Silver Spring	4c. County of Death Montgomery
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 578-06-3651 1 M 2 F 53 Yrs.	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Jan. 29, 1953 Co配力) Salvado
Maryland 28a-f show any <u>d at once.</u>		Usual Residence of Decedent 10a. State		10d Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once.	I Director	3808 Littleton Street	20906	USA
r death w	by Funeral	1 Never Married 2 Married Armed Forces? If Yes 1 Yes 2 No 1 X Widowed 4 Divorced or Dates: 1 X Y	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto F El Sal Yes 2 No specify:	vador Vador Specify: White, etc. White White
5-0036 led within 72 hours afte Hygiene other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	: Usual Occupation (Give kind of wo it of working life. DO NOT use retire ekeeper	ork done and and a strict of Business/Industry and a strict of Business/Industry and a strict of Business/Industry or Business/Industry and a strict of Business/Industry or Business/Industry and a strict or Business/Industry or Business/Ind
e, MD 21215-0036 1 and 2 should be filed within 7 Health and Mental Hygiene item 27 is marked other than r traumatic event, the Medica	Be	17. Father's Name (First, Middle, Last) Genobel Ramirez 19a Informant's Name/Relationship (Type, Print) 19b. Mailing A	Eusta	First, Middle, Maiden Surname) quia Torres ural Route Number, City or Town, State, Zip Code)
MD 2 nd 2 shoul lith and M m 27 is n aumatic		Rubin Diaz/Brother-in-law 1164	Le Baron Ter	race Silver Spring,Md209
Baltimore, MD 2121: permit Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event.	9	4 Donation 5 Other Specify:	rplace) Heaven Cem.12	Date 20c. Location - City or Town, State /12/06 Silver Spring, Md
Balt permit Depart Impor				I FUNERAL SERVICE,P.A. lvd.Silver Spring,Md2091
Physician /Medical		23a. Part I. Ent. The disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac or	respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
ecuted and - transit	Examiner	(C) (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of).		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death for the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.		past 12 months?	I death 3 Ectopic pregnan	23d Date of delivery Month Day Year
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Division of Vital Records, P.O. ral or strending Physician: The law requires that the safer death al Director. After this certificate has been signed by led in by the funeral director, page 2 should be dead.	Completed			24a. Was an autopsy fundings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
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of Vit ing Physic After this uneral dir	은	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b Time of Injury		g Home 5 Residence 6 Other: Scene 28d. Describe how injury occurred
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Division pital or Attend ours after death teral Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, (Specify) Local Street		28f. Location (Street and Number or Rural Route Number, City or Town, State) Seorgia Ave, Silver spring, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurred at	due to the cause(s) and manner as stated the time, date and place, and due to the cause(s)
/0	Me	29b. Signature and title of certifier W, MD	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) December 8, 2006
		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street,	, Baltimore, MD 21201	

State 31. Date filed (Months 2 Year) 2 2006

		ı	For State	State	of Marylan		artment of H		Mental Hygie	ene 3. No 2006	1.11.17
			Registrar 1. Decedent's Name (First, Mid.	dle, Last)			tinoato or E	Journ	2. Date of Death		3. Time of Death
	Physici /Medic		Frances		Virgini	a	Thomas		Month December	Day Year 2006	9:25 P M
	Examin		4a. Facility Name (If not instituti	on, give street and n	umber)		4b. City, Town, or	Location of Death	ı	4c. County of Dea	ith
			Beverly Living		Cumber	land		erland		Alle	gany
	Funeral Director		5. Social Security Number 215-12-2591	6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs.) 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 08/17/19	Year) C	thplace (State or Foreign ountry)
	pu *		Usual Residence of Decedent 10a, State 10b, Coun		10c Cib	y. Town or Lo	cation				10d. Inside City Limits
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036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28e-f show or other traumatic event, its Medical Examinar must be notified.	by Funeral	11. Marital Status 1 Never Married 2 M Ma 3 Widowed 4 Divorce	Armed F arried 1 _ Yes If Yes, G	2 XNo		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☒ No	n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi Specify:	
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	and 2 leafth a m 27 ls		Gary W. Thomas	s / son		1240	Oakland	Terrace	Road, Ba	ltimore,	MD 21227
Baltimore,	Pages 1 nent of He ant: If iten ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other		State	emetery, crer	sition (Name of natory or other place	1	Date 20	Oc. Location - City or Flintst	
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signatury of Funeral Service		1		. Name and Addres	s of Facility A	dams Fami		1 Home, P.A.
	*		23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that st only one cause on	caused the death each line.		er the mode of dying	g, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death
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8760,	cate be executed physician and the burial-transit	al Exa	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):					
587		edical		d.							
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 Petal mant at time of de nown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
٩		by	Part II. Other significant condl	tions contributing to	death but not resu	ulting in the u	nderlying cause give	on in Part I.	23e. Did toba 1 ☐ Yes	~	o the cause of death?
Records,	The law requires ate has been sign page 2 should be	Completed							24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medic examiner?						th (Check only one)		
of	Si Si	To To	1 Yes 2 No	Hospital: 1 = 28a. Date	Inpatient 2			Nursing H		ce 6 Other (Spe	ocify)
no	ding After fune	tion	1 Matural 5 ☐ Pend		nth, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ 1	au ? ′es 2 □ No	28d. Describe how	injury occurred	
Division	I or Attending after death. Director: After	ertification:	3 Suicide 6 Coul	d not be 28e. Place	e of Injury - At ho ding, etc. (Specily	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 12 Certify (Check only one) 1 Medica	ring Physician: To the al Examiner: On the and ma	e best of my know basis of examinat nner stated.	wledge, death tion and/or inv	n occurred at the time vestigation, in my op	e, date and place sinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as e and place, and due	s stated. a to the cause(s)
	To th withir To th comp	Me	29b. Signature and titlerof certif	ier A		/ /\	29c. License	number		Date signed (Mont	
	2		1 teles	of cel	1107	1719	100	448/	()	ecember	7,2006
	nes		P. H.	A L Mo S	100	000	(artin	gfor (out, Ca	mbilan	9,2006 1,01d2152
	Sta Registr		DEC 1 2	006	Registrar's Signal	docs.		U	/		

		,	For State Registrar	State o	of Marylan		artment of I		nd Me	, ,	jiene	6 41	119
	*	Н	Decedent's Name (First, Middle,	Last)					1	2. Date of Dea Month	th	3. Time of	Death
ă	Physicia /Medic		EMORY	VIRGI	L	TUR	NER				er 12, 200		2 P M
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town,	or Location of	f Death		4c. County of D		
			Memorial Hospi				Cumber				Allega:	ny	
	Funeral		,	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.	la <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days		Min.	 Date of Birth (Month, Day) 	, Year)	Birthplace (State of Country)	r Foreign
Į.	Director		235-30-2022 Usual Residence of Decedent	- X	82	115.				06/01/	1924 W	est Virgi	inia
	and w		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside Cit	ty Limits
	Maryl f sho ied a	lor	MD All	egany		(Cumberlar	nd				1 X Yes	2□No
	28a notif	Director	10e. Street and Number				10f. Zip Code			1	l0g. Citizen of What	Country?	
	leath with the Marylar ns 23a or 28a-f show must be notified at		1017 Frede	rick Stre	eet			21502			USA		
	hours after death with the Maryland tural", or Items 23a or 28a-f show at Examiner must be notified at	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Orig	in? (Spec	ify Yes or No-		merican Indian,	
9	after or Ite mine		1 ☐ Never Married 2 🎇 Marrie	ed 1 X Yes	2 No 194	13-	n res, specily cui 1 □ Yes 2 👿 No		, rueno n	ilcan, etc.)	Black, W		
2-003	ours iral'; Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	Dates: 194	16	TET TES ZENTO	эреспу.			Specify:	White	
	72 dlc	Completed	15. Decedent' (Specify only highes	s Education t grade completed)		16a. Decei (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most	of working	g	16b. Kind of Busine	ss/Industry	
121	within	E I	Elementary/Secondary (0-12)	College (1-4or 5+)	_	ner and (Restaur	on t	
2	e filed within al Hygiene. other than ' vent, the Me		12 17. Father's Name (<i>First, Middle, L</i>	ast) 2		OWI	ier and c	1		(First Middle I	Maiden Surname)	ant	
and	be de de eve	To Be	Martin	В.		Turner	n	Sara		E.		anFleet	
Mary	s 1 and 2 should t Health and Men tem 27 is marke other traumatic	-	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailir	ng Address (Stree	t and Number	r or Rural	Route Number	r, City or Town, Stat	e, Zip Code)	
_	and 2 sealth ar n 27 is ler trau		Glendora L. Tu	rner / w:	ife	1011	7 Frederi	ick St	reet,	Cumbe:	rland, MD	21502	
e,	es 1 a of Hei	Н	20a. Method of Disposition	0 DD	20b. P	lace of Dispo	sition (Name of matory or other pla	ace)	Da	ite	20c. Location - City	or Town, State	
altimore,		Н	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State		Mem. Pa		2/15/	2006	Cumberla	nd, MD	
a	permit. Pag Department Important: I any injury o		21. Signature of Fundral Service L	icensee							ily Funer	,	P.A.
<u>m</u>	9 9 E 8 9	()	Liber C.	alle			104 Decat	tur Sti	reet,	Cumbe	rland, MD	21502	11
			23a. Paft1. Enter the disease, or o shock, or heart failure. List of	complications that only one cause on a	caused the death each line.	n. Do not ent	er the mode of dy	ing, such as o	cardiac or	respiratory arr	rest,	Approximate Interval Bety	een
3	Physician		Immediate Cause (Final disease or condition	_a	-orona.	64	ASTERY		(1500	3l		Onset and D	now
ji S	/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):	11: 10	01.	1 0		0:00 0	11016	
	Examine:	<u>_</u>	Sequentially list conditions,	b. Choor	(or as a consequ	OPZ18	uchke	Pu	Imu	ruin)	Cal Hat	a and	1000
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Come	e shirt o	J	Part	Co	Alle	20	diseas	Unla	odia.
,	execunand nandial-tra	Examiner	that initiated events resulting in death) Last	c. Du⇔to	(or as a consequ	uence of):	,,,,,,,	7		7 4 C		1	700
760	ate be executed hysician and the burial-transit	ical		d									
89	rtifica ng phr as th	~	IS SSMALE.								T 2		
Box	leath certific attending p	an/I	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregna birth 2 Feta		DEctopic pregnanc	cy			23d. Date of	•	
	at the dea by the at tached fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregi 9□Unkn	nant at time of d		Other (specify)				Month	Day Y	/ear
<u>о</u>	hat the		Part II. Other significant condition	ns contributing to d	leath hut not resu	ulting in the u	nderlying cause di	ven in Part I		23e Did tol	bacco use contribute	e to the cause of de	eath?
Vital Records,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	l by					naon, mg oaabo gi	ron in arti			es 2□No 3□		
000	v requ	etec								24a. Was a	24h Word	autopsy findings a	available.
Ř	slcian: The law certificate has t irector, page 2 s	Completed								autops perfori	sy prior med2 death	to completion of ca 1?	ause of
ā			25. Was case referred to medical					26 Place	of Death	1□ Yes (Check only on	2 2 No 1 □ Y	′es 2□No	
	ystcia is ceri direct	o Be	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2□	ER/Outpatier	nt 3 DOA Ot	har:			ence 6 Other (S	(necify)	
0	ding Phy n. After this funeral c	_	27. Manner of Death	28a. Date		28b. Time o	f 28c. Inju				ow injury occurred	poony	
000	endir ath. or: Af he fui	atio	1 XNatural 5 Pending 2 Accident investig	ation	,,,	,,		Yes 2 N	10				
Division or	or Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and Zoe. Flace	e of injury - At ho ling, etc. <i>(Specif</i>)	me, farm, str //	eet, factory, office		28	3f. Location (St City or Town	treet and Number or n, State)	Rural Route Numi	ber,
	pital purs a control a con		29a. Certifier 1 Certifying	Physician: To the	e hest of my kno	wledne dest	h occurred at the t	ime date and	d place, as	nd due to the c	ause(s) and manner	r no ototod	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filed in by the funeral director,	Medical	(Check only 2 Medical E	xaminer: On the b	pasis of examina oner stated.	tion and/or in	vestigation, in my	opinion, deat	th occurre	d at the time, d	late and place, and	due to the cause(s))
	To the within To the complex	Me	29b. Signature and title of certifier	9			29c. Licen	se number		2	29d. Date signed (M	onth, Day, Year)	
	7.1		Moder				DOC	060478			December	12 .,	2006
-	5/10A		30. Name and addless of person v						MI	21502			
	n Ls	to.	Afaq Ahmad, 31. Date filed (Month, Day, Year)		625 Kent egistrar's Signa		ue, Cumbe	eriand	, MD	21502	-	_ <u>- </u>	
	Sta Registr		DEC 14		China de la composición dela composición de la composición de la composición dela composición dela composición dela composición de la composición dela composición de la composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela		arke						

			1 - For State Registrar	State of Man		artment of F			iene	06		19
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h Day	Year	3. Time of	Death
	Physici /Medio		Warren Louis T					Decembe	r 5, 20	006	11:11	Ам
	Examir	er	4a. Facility Name (If not institution, give s			4b. City, Town, or		ith	4c. County			
			Carroll Hospital Ce			Westmins			Carro) TT		
	Funeral		5. Social Security Number 6. Sex	M 2□F 7. Age (/	n yrs. last birthday Yrs.	Months Days	If Under 24 Hr. Hours Mir		Year)	9. Birthp Cour	lace (State or itry)	Foreign
	Director	,	035–18–9523 ¹⅓	- 04	115.			July 3,	1922	Mass	achuse:	tts_
	land		10a. State 10b. County	16	Oc. City, Town or L	ocation				1	0d. Inside City	y Limits
	Mary	ō	MD Carroll	Į.	Vestminst	er					1 🗆 Yes	
	28e	Je C	10e. Street and Number			10f. Zip Code		11	Og. Citizen of \	What Cour	ntry?	
	3a or	ā	806 Fairfield Ave.			21157			USA			
	ms 2	Funeral Director	11. Marital Status 1	2. Was Decedent Eve	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or No-		e - Americ		
٥	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No		If Yes, specify Cuba		nto Hican, etc.)		ck, White,	etc.	
3	72 hours after death with the Maryland Instural, or Items 23s or 28e-f ehow disal Examinar must be notified at	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2√2 No	Specify:		Specify	Wh	ite	
'n	n 72 hours after death with the Marylan "natural", or Items 23s or 28e-f ehow silical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	edent's Usual Occup	durina most of we	orking	16b. Kind of B	usiness/ind	dustry	
7	within ene. than "	m Id	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	1)					
7	e filed with Il Hygiene. other than		17. Father's Name (First, Middle, Last)	2	Tax	Auditor	19 Mothada Na	ame (First, Middle, M	State o		yland	
משם	ntal h	Be							таюел Битап	10)		
Š	should be and Mental marked umatic ev	2	George Henry Theri 19a. Informant's Name/Relationship (Typ.		10h Mail	ing Address (Street		Levesque	C't T	Ca- a- 70-	0-4-1	
<u>7</u>	nd 2 s lith an 27 le i		Dorothy Scanlan - I					Rural Route Number, ., Westmir				
ā,	E E		20a. Method of Disposition		20b. Place of Disp	osition (Name of			20c. Location -			
2	Pages nent of int: If Its iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Carroll	Cremation	ns 12	/08/2006				
Dalitimo	표원를 .		21. Signature of Funeral Septice Lidense	9	2	2. Name and Addres	ss of Facility Dr	ritts Fune	ral Ho	mo &	Chamal	D 7
0	perm Depa Impo any l		Marke A Josh	-							-	, F.F
			23a. Part1. Enter the disease, or complic	ations that caused the	e death. Do not en	ter the mode of dyin	g COII RO.	Westmir was or respiratory arre	ster,		Approximate	-
	Physician		Immediate Cause (Final	e cause on each line.	4						Onset and D	
	/Medical		disease or condition resulting in death)	Due to be as a c	onsequence of):		· · · · · · · · ·					
	Examiner			Chron	nic Luna	Pisease Infection					5 yrs	
_		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):			0				
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Chron	nic Lune	Infection	-Fun	gal			5 yrs	
00,	ate be executed hysicien and the burial-transit	EX	resulting in death) Last	Due to (or as a co	onsequence of):			3			5 yr	1
0	cate b	dicai	d.	DVM	chiectas	3					3 4	
O X	ertific ding p	Physician/Med	tF FEMALE:									
S C	attend attend for us	ian	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of p	Fetal death 3	Ectopic pregnancy			23d. Dat Mo	te of delive nth	•	ear
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tim 9☐Unknown	e or death 5	Other (specify)						
ŗ	that t		Part II. Dther significant conditions cont	ributing to death but n	ot resulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use conti	ribute to th	e cause of de	ath?
corus,	Physician: The law requires that the death certificate this certificate has been signed by the attending physial director, page 2 should be detached for use as the	d by				, ,			s 2 🗆 No		ably 4 ∐Ur	
3	w req beer shou	iete						240 Mino or	245.1	Mara autor	an findings of	unilable.
Į L	he lay	Completed						24a. Was ar autopsy perform	, ,		osy findings a nptetion of ca	
A II G	in: Ti ificate or, pa	C	25. Was case referred to medical							Yes	2 🔼 No	
>	s cert lirect	To B	examiner?	ospital:	2 ER/Outpatie	nt 3 DOA Othe	0.5	eath (Check only one Home 5 Reside		10		
5	g Phy er this eral c		27. Manner of Death	28a. Date of Injury (Month, Day Ye				28d. Describe ho			"	
202	ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ea <i>r)</i> Injury		k? Yes 2∐No					
2	ar deg	III C	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, st	reet, factory, office		28f. Location (Str. City or Town,	eet and Numb	er or Rura	Route Numb	ΘΓ,
5	tel or rs aft el DII ed in	Certification:		building, etc. (c	Spocity/			Ony or rown,	State/			
	To the Hospitel or Attending Physicien: The law within 24 buours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2.		(Check only 2 Medical Examin	cian: To the best of m	ny knowledge, dear	h occurred at the tim	ne, date and plac	e, and due to the ca	use(s) and ma	inner as st	ated.	
	the hin 24 the fundamental the	Medical	unej	and manner stated								
	4		29b. Signature and title of certifier)		29c. License		1	d. Date signed	1		
	M2173		11-8-1		- 0	DOO	62791		12/7	106		19.
	15		30. Name and address of person who con	11. ()		Print)	50 51	Bladock #2	VO BA	Him	ne, my	D
	Sta	te	31. Date filed (Month, Day, Year)	82. Registrar's		IN NO MODELL	e 31.	JINIULIU . A	10	21	28/	
	Registr		DEC 0.8.21	nne Maner	. K	frank 1						

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I rtificate of		Mental H	ygien Rag. Ni	CUUD	41420
			Decedent's Name (First, Middle, I	Last)				2. Date of D	eath		3. Time of Death
1	Physici /Medi		MATHIAS]	KAMANA	UKITEYEI	Ι		DEC.	6.	2006	21:45p ^M
	Examir		4a. Facility Name (If not institution, g	•		4b. Cily, Town,	or Location of Dea	ath	40	c. County of Deat	
		R.M.	SHADY GROVE								MERY CO.
	Funeral			Sex 7. Ag	e (In yrs. last birthday,	If Under 1 Year Months Days		n. (Month, E	ay, Year		hplace (State or Foreign untry)
	Director		579-88-0189 Usual Residence of Decedent		67 Yrs.			8-12-	-193	9 KII	NSHASA
	anyland ahow		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Mar 9-1-8	ţċ	MD MONTGO	OMERY CO.	GAITHE	RSBURG					1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	untry?
	ath w		20438 MEADOW 1	POND PLACE	E	208	86			U.S.A	•
	er de	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	10-	14. Race - Ame Black, White	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 I If Yes, Give Year or Dates:	No .	1 □ Yes 🛣 No					BLACK
21215-0036	within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28e-f ahow the Madical Examinat must be mailfied al		15. Decedent's		16a Dece	dent's Usual Occu	nation		16b k	Kind of Business/	inductor
15	n 72	piet	(Specify only highest of	grade completed)	(Give	kind of work done DO NOT use retire	during most of w	orking		ONTGOME	,
212	ed within giene. ar than "t	Completed	Elementary/Secondary (0-12)	College (1-4or 5)+)	COUNSEL	OR			CHOOL S	
	無いま	Bec	17. Father's Name (First, Middle, La	st)				ame (First, Middl			7101111
/lai	should by	Tof	ALBERT PU	IGU UK	ITEYEDI		WOY	WOHAI	ıΙ	AKAKI	3
Maryland	C1 00 6		19a Informant's Name/Relationship SOPHIE UKITE	(Type, Print) ZEDI - WI	FE 19b. Maili	ng Address (Street	and Number or F	Rural Route Num	ber, City	or Town, State, Z	(ip Code) 20774
	l and selfth im 27 her tr		MUKANDO UKITE	EYEDI - S	ON 1411	2 WATER	FOWL W				
Baltimore,	& O		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3	☐Removal from State		matory`or other pia	· ·	Date		ocation - City or	
ţi			4 Donation 5 Other (Spec	**	ALL SOU						
Ba	permit. Departr importe any inju		21. Signature of Funeral Service Lic	ensee Ol		2. Name and Addre	-			UNERAL	
			23a. Part1. Enter the disease, or co	molications that caused						W WASH.	DC 20001
3	le Discontaine		shock, or heart failure. List on Immediate Cause (Final	ry one sause on each in	10.						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		CRANIAL H a consequence of):	EMORRHA	GE, NON	ITRAUMA	TIC		1 DAY
i i	Examiner			Duo 10 (01 a3	a consequence or,						
		Jer	Esquentially list eor dittors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	cuted nd ransil	Examiner	that initiated events	C.							
Ö,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as	a consequence of):						
8760,		Physician/Medicai	•	d							A MATERIAL PROPERTY.
9	death certific e ettending p id for use as	/Mec	IF FEMALE:	220 14 1100 0110000							
Вох	eath certifi ettending I for use as	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	у			23d. Date of delin	very Day Year
o.	that the de led by the delached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Pregnant at 9□ Unknown	time of death 5L	Other (specify)					,
a	The law requires thet the steep has been signed by the page 2 should be detache		Part II. Other significant conditions	contributing to death be	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rds,	quires n sign	d by						1 🗆	Yes 2	□No 3□Pro	bably 4 Hunknown
CO	w requir s been si should	Completed						24a. Wa	s an	24h Were aut	opsy findings available
Re	The la	E O						auto perf	opsy ormod?	prior to c death?	ompletion of cause of
ta	hysicien: The law nis certificete has I I director, page 2 s	BeC	25. Was case referred to medical				26 Place of De	1 Yes	2 No	1 Yes	21 No
\	Attending Physicien: r death. ector: After this certification in the funeral director.	ToB	examiner? 1 🗆 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Outpatier	it 3 DOA Ott	vac.			6 ☐Other (Spec	ıfv)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju- (Month, Da)	y Year) 28b. Time o	28c. Injui Wor		28d. Describe			
Sio	endir sath. or: Al	atic	2 Accident investigati	on			Yes 2 □ No				
Division of Vital Record	i or Attenation after deati	Certification:	3 Suicide 6 Could not determine		ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location City or To	(Street ar	nd Number or Rui	ral Route Number,
	lospital of hours all unerel D										
	T 4 T A	edical	29a. Certifier (Check only one) 1X Certifying F 2 ☐ Medical Exit	Physician: To the best of aminer: On the basis of	examination and/or in	e occurred at the till vestigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time	cause(s , date an) and manner as d place, and due	stated, to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner sta	uou.	29c. Licens				te signed (Month	
	F 3 ∓ 8 -		Den Da	46			64508	-			9,2006
0	(10)		30. Name and address of person who	o completed cause of de	Bath (Item 23a) (Tune		4-1900			2 1 - 0.	17
16	(10)		BRIAN CARPENT		MEDICAL	·	שמדמת	DOCETT.		, MI	20050
† .4	Sta	te	31. Date filed (Month, Day, Year)	2. Registra	ar's Signature	E)	VIVI VIV	NUCKV.	ال الماليات	THE THE	20850
20	Registr	ar	DEC 1 2 200	U Decem	N. Marie	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 06:03 A M **Physician** DECEMBER 09 2006 HAZEL L. WALLS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL AGNES BALTIMORE AINT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕇 F Months Days Hours 579-03-9008 01 - 03 - 1910Director 96 Selma, Iowa Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 KrYes 2 □ No Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 709 Maiden Choice Lane #RGT414 <u> 21228</u> USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 KWidowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Hygiene. Bookkeeper Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fi th and Mental H 7 is marked oth Be Sarah Snook ည Issac Murphy permit. Pages 1 and 2 shr. Department of Health and Mimortant: If flem any Injure. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5008 Dalton Street Camp Springs, Md. 20748 James Walls/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 12-14-06 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mary MO/374 Cedar Hill FH 4111 PA Ave. Suitland, Md. 20746 Hedgman 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS WEEK **Physician** /Medical Due to (or as a consequence of): MYOCARDIAL I WEEK Examiner INFARCT Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 menths? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform has certificate 1 Yes 2√ No director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 K No 2 ER/Outpatient 3□ DOA Medical Certification: To this Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

DEC 12 2006

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DEC 1.2 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

BALTIMORE

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			1 - For State Registrar) (ficate of l			Reg. I	とせせ	0	1 422
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28	Examin	er	4a. Facility Name (If not institution, giv			4	4b. City, Town, or		eath		4c. County o	of Death	
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_	itami	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 Yes 2 10		13. Wa	is Decedent of Hi 'es, specify Cuba	ispanic Origin In, Mexican, P	? (Specify Yes or uerto Rican, etc.	No-		e - Americ k, White,	
936	ai', or	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		10]Yes 2☐XNo	Specify:			Specify:	Wh:	ite
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural; or itame 23a or 28a-f show event, the Medical Exatt her must be motified at	Completed	15. Decedent's Ed (Specify only highest gra		1	6a. Deceder (Give kir	nt's Usual Occupand of work done of NOT use retired	ation during most of	working	16b.	Kind of Bu	siness/Inc	lustry
121	within ane. than '	ршо	Elementary/Secondary (0-12)	College (1-4or 5	+)		stered N				M	edica	.1
2	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last,			negi	stered i		Name (First, Mic	ldle, Maid			1.1.
lan		ToB	Francis Joseph M	lulcahy				Clar	a L. Hur	rd			
Maryland	2 sho and l		19a. Informant's Name/Relationship (r Rural Route Nu		_		
	of Health of Health item 27.		Mary Weller Rose 20a. Method of Disposition	/ daughter			amilton ion (Name of tory or other plac		Ln. Kno		le, T		7922 wn. State
Baltimore,	nit. Pages 1 and 2 should artment of Health and Mer ortant: If item 27 Is marke injury or other traumatic.		W Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		I .				/11/2006				
a	permit. Page Department of important: if any injury or once.		21. Signature of Funeral Service Licer		111	22. 1	Name and Addres	s of Facility	Beall Fu	ınera	1 Home	оц, г е	WD•
m —	8 9 11 2		· Con	in tou	elf	65	12 NW CI	ain Hw	y. Bov	vie,		20715)
			23a. Part1. Enter the disease, or com shock, or heart failure. List only		~								Approximate Interval Between Onset and Death
	Physician / /Medical	1)	Immediate Cause (Final disease or condition resulting in death)				TORY	FA	ILLUR	E			
P	Examiner			Due to (or as a		,	AL D	ERIL	ITY				
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9	tificate ng phy as the			u					****				
Box	eath certifici attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal de	ath 3□Ed	ctopic pregnancy				23d. Date Mon	e of delive	ry Day Year
	he dez	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 □ C	other (specify)			-	WOI	ILI I	Day Teal
0.	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	by Ph	Part II. Other significant conditions of	contributing to death bu	ut not resultin	g in the unde	erlying cause give	en in Part I.	23e. D	id tobacc	o use contri	ibute to th	e cause of death?
rds	w requires been sign should be	ed b	HYPER-	TENSI(MC				_ 1	Yes	2 X No	3 🗌 Prob	ably 4 Unknown
eco	law re as be	Completed	DIABETE	JM 2	LLITI	4S			24a. V	Vas an utopsy	24b. W	Vere autor	osy findings available inpletion of cause of
E E			HYPERC	HOLEST	FERO	LEM	1A			erformed s 2 X	d d	eath?	_
Ž	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	- 2005	(0	20 DOA Othe		Death Check or				An Esta Tue
Division of Vital Records,	Attending Physician: sr death. ector: After this certifically the funeral director.	\vdash	27. Manner of Death	28a. Date of Injur (Month, Day	nt 2 ER/	b. Time of	28c. Injury Work	4 A INUISI	ng Home 5 ☐ F)
Sior	endin sath. or: Aft he fun	atio	1 Natural 5 Pending 2 Accident investigation	n	/ (Bai)	Injury		Yes 2□No					
Š	for Attendate death Director.	Certification:	3 Suicide 6 Could not b			, farm, stree	t, factory, office			n (Street Town, St		or Or Rura	Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: v completely filled in by the f		29a. Certifier 1 Certifying Ph	nysician: To the best of	of my knowled	dge, death o	ccurred at the tim	ne. date and p	lace, and due to	the cause	(s) and mar	nner as si	ned.
	n 24 h	edical	(Check only 2 Medical Exar	miner: On the basis of and manner sta	examination	and/or inves	stigation, in my op	oinion, death o	occurred at the tir	ne, date a	ind place, a	nd due to	the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier				29c. License	number	_	29d. [Date signed	(Month, L	Day, Year)
	OF)		30. Name and address of person who	M.	<u>)</u>		900	4521	7		12/6	>7/2	0006
1	2 (5)		ADEBOWALE	completed cause of de	eath (Item 23	a) (Type, Pri	(+000	whe II	RNHUI	5	06.	Ph	MD 2671
	Sta	- 1	31. Date filed (Month, Day, Year)	. 32. Registra	ar's Signature	1 3				الكاكب	Je		1-11 2014
	Registr	ar	DEC 12 2006	Barrie	1. K	goere							

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DEC 6 ²2^y006 Yeer LACULIA Ρ. WILLIAMS **Physician** 2:33PM_M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHEVERLY P.G. PRINCE GEORGE'S HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MARCH | 3 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1934 Funeral 1□M 2√2F KENTUCKY 72 Yrs. 577 50 6472 Director Usual Residence of Decedent daath with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Exeminer must be notified at 1 XYes 2 ☐ No SPRINGDALE P.G. Directo MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3610 ST JOHNS PLACE 20774 USA or items 23a Funeral 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Healin and Mental Hygiene. Important: If item 27 is marked other than "natural", or item eny injury or other traumatic event. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 Yes 2 No Specify: <u>م</u> 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PVT. HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLOVIS PERKINS MARION THOMAS ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3610 ST JOHNS PL. SPRINGDALE MD. 20774 FRANCIS L. WILLIAMS/HUSBAND 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MÉM. PARK 12/11/06 LANDOVER MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility WATSON F. H. 21. Signature of Funeral Service Licensee 3435 14th ST., N.W. WASH. DC. 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE **Physician** /Medical Due to (or as a consequence of): Examiner HYPERTENSIVE CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2X No the detached 9 Unknown 9 Unknoy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed? certificete l 1 Yes 2 XNo Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one, examine?? 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 KER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 Yes 2 No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Predical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely (Check only one) and manner stated. within 2. To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

DHMH 17 Rev 1/2001

State Registrar

RIVERBEND RD. FT. WASHINGTON,

MD.

20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

600

32. Registrar's Signature

ROLLE,

ALBERT E.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Sandra Cecelia Williams /Medical December 6 2006 2:37 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months Days Hours Min. Director 577-70-4696 June 5, 1949 Wash. DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 'natural', or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 17⊈Yes 2 No Directo Maryland Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6429 Pennsylvania Ave., #103 Funeral 20747 United States 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 27 No Specify: <u>≨</u> Specify: 3 Midowed 4 Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Administrative Assistant permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important; If item 27 Is marked other any Injury or other traumatic event, the Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Warren W. Carroll ပ Julia Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa R. Williams/Daughter 4033 - 7th St., NE #2, Wash., DC 20017
Date 20c, Location - City or To 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 12/11/2006 Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 23a. Part1. In er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C u e (Final disease or contion resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trai Due to (or as a consequence Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 √Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar (Check only one)

30. Name and

29b. Signature and title of certifier

ESANMI MI) 7503 31. Date filed (Month, Day, 32. Registrar's Signatu DEC 0 8 2006

s of person who completed cause of death (Item 23a) (Type, Print)

To the

29c. License number

ROAD CLINTON MO 20735

			1 - For State Registrar	State of	f Marylan		artment of H tificate of I			jiene 2006	41425
	Physici	ian	Decedent's Name (First, Middle, L MILLIE	.ast)		WILLI	AMS		2. Date of Dea Month December	Day Year	3. Time of Death 6:54 P M
	/Medio Examin		4a. Facility Name (If not institution, g	ive street and nun	nber)	*******	4b. City, Town, or			4c. County of Dea	
			2551 MULLINIX M 5. Social Security Number 6.		7. Age (In yrs.	last hirthday)	Mount At	ry If Under 24 Hrs.	8. Date of Birth	Howard	thplace (State or Foreign
	Funeral Director		432-62-6068	1□M 2XF	68	Yrs.	Months Days	Hours Min.	(Month, Day	(Year) C	ckansas
7	pug M		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryli	tor	Md. Howa	rd	į.	ount A					1 □Yes 2 No
	or 288	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What C	ountry?
	eeth w		2551 Mullinix M		ident Ever in U	S 13 V	217 Was Decedent of H		pecify Ves or No-	United St	
20	be filed within 72 hours after deeth with the Maryland nat Hygiene. ad other then "naturel", or iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For	rces? 2XNo e	1	f Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	o Rican, etc.)	Black, Whi	
0-00-c	72 ho	eted	15. Decedent's (Specify only highest of	Education grade completed)		16a. Deced	lent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of wor	rking	16b. Kind of Business	/Industry
7	within iene. then	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		emaker)		Own Home	
ana	ld be filed ental Hygic ked other ic event, II	To Be C	17. Father's Name (First, Middle, La Winifred Clean	st)				18. Mother's Nar Blanc	ne (First, Middle, i		
Mary	and 2 should be ealth and Mental in 27 te marked out traumatic even	-	19a. Informant's Name/Relationship James C. Strouth		and					r, City or Town, State, t Airy, Md	,
saitimore,	permit. Pages 1 and 2 should Depertment of Health and Men Important: If Item 27 le marke eny injury or other traumatic: once		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control Con		State	semetery, crer	sition <i>(Name of</i> natory or other plac itan Crem		Date 11/06	20c. Location - City of Alexandri	
Dall	permit. Depertraimports eny inju		21. Signature of Funeral Service Lic	ensee	Sarch	w 22	Name and Address Muriel P. O.	ss of Facility H. Barbe Box 5038	r Funera	l Home sville, Md	. 20882
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on e	aused the deat ach line. O Co or as a conseq	n		g, such as cardiad			Approximate Interval Between Onset and Death Common Market M
oo,	ficate be executed physicien and s the buriat-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a conseq						
00/00	ficate physics the l	edical		d							
O. BOX	law requires that the death certifi as been signed by the ettending 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		inth 2 ☐ Feta ant at time of d	I death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
ras, r.	quires that I n signed by uld be deta	by	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
ı Records,	The ate h page	Completed							24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of
VII	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe		ath Check only on		
5	P in the	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date o	of Injury	28b. Time of	28c. Injun	/ at		ence 6 Other (Spe	ecity)
SIOU	ttending I death. tor: After the funer	atio	1	non	th, Day Year)	Injury	M 1 🗆	Yes 2 No			
<u> </u>	ital or Att is efter de ai Directe led in by t	Certification:	3 Suicide 6 Could not 4 Homicide determine	ed 289. Place buildir	ng, etc. (Speci	fy) 	eet, factory, office		City or Town		
	To the Hospital or Attanding within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	Aedical	one) 2 Medical Ex	aminer: On the ba	asis of examina ner stated.	ition and/or in	vestigation, in my o	pinion, death occu	irred at the time, d	ause(s) and manner a late and place, and du	e to the cause(s)
	or with	×	30. Name and address of person when DAULO B. HAP. 31. Date filed (Month, Day, Year)	B Har	long	mo	035	9 6 5	D	29d. Date signed (Mon OF CEMBER	11, 2006
			30. Name and address of person who DAU(0 B HAR)	o completed caus	e of death (Iter	n 23a) (Type,	NIER S	T. #200	MT.	my, mo	2177/
	Sta Regist		31. Date filed (Month, Day, Year) OEC 12	472	yisuai s siyili	S. A.	radio				

			1 - For State Registrar	State of Maryla		artment of F			jiene 006	41426
П	Physic	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Year	3. Time of Death
	/Medi		Frances	Iren	e	Wilhelm		Decemb	,	
	Examir	ner	4a. Facility Name (If not institution, give s			4b. City, Town, or		ath	4c. County of Dea	ath
			Devlin Manor Heal 5. Social Security Number 6. Sex				rland	G.	Allegar	
	Funeral Director		233-34-5616	M 217 82	rs. last birthday) Yrs.	Months Days	Hours M	in. (Month, Day	Year)	rthplace (State or Foreign Country)
			Usual Residence of Decedent	02			L	07/12/	1924 M	aryland
	how		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	e Ma	cto	PA Bedford		Bedfo	rd				1 ☐ Yes 2 ☐ No
	्रे 0 28	Director	10e. Street and Number	22 5		10f. Zip Code		1	0g. Citizen of What C	country?
	ath w		961 Bedford V				5522		USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or itams 23s or 28e-f ahow other traumatic avant, itis Marikal Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 [汉] No	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
Ö	tural E	edt	15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occup	ation			White
15	n n	Completed	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	durina most of w	vorking	16b. Kind of Busines:	sylindustry
2	d with	E O	Elementary/Secondary (0·12)	College (1-4or 5+)	Н	omemaker			Home	
פ	ould be filed v Mental Hygie harked other i	0	17. Father's Name (First, Middle, Last)		113	Janemarker	18. Mother's N	lame (First, Middle, I		
<u> a</u>	vid b Menta rrked	To B	Floyd	Erman	Bryant	;	Haz	el	Harriette	Slippey
Maryland 21215-0036	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Typ						City or Town, State,	Zip Code)
	1 end 1 Health em 27		Rebecca E. Mesa /			-	Round	Hill, Virg	ginia 201	42
altimore,	of H If Ital		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	1	. Place of Dispo cemetery, cren	sition (Name of natory or other place	9)	Date	20c. Location - City of	r Town, State
Ē	permit. Pages Department of i Important: If It any Injury or o		4 ☐ Donation 15 ☐ Other (Specify)	Cu		nd Cremat			Cumberlan	
a	permit. Departr Imports any Inju		21. Signature of Fur eral Service License	e 7						l Home, P.A.
	doled		Tracket C. C	llone				et, Cumber	<u> </u>	21502
		S V	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	ath. Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Zu	ny Con	u				2 mm
	Examiner			Due to (or as a conse	equence of):					
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):					
	ansit	Examine	if any, leading to immediate cause. Line Ulushing Cause (Disease or injury that initiated events							
o o	an an		resulting in death) Last	Due to (or as a conse	equence of):					
9/8	death certificate be executed e attending physician and of for use as the burial-transit	dical	d.							
õ	artifica ing ph a as t	യ	IF FEMALE:							
ROX	eath certifi attending p I for use as	ian/M	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3 [Ectopic pregnancy			23d. Date of de	
5	at the dea by the a tached fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Year
	that the	Physicia	Part II. Other significant conditions conf	ributing to death but not re	eculting in the us	adachtina causa anta	o in Deet I	220 Did tob		- h
က်	requires that een signed b	d b	Parenegalanta		southing in the th	idenying cause give	miniranti.	1 ☐ Ye	accouse contribute to s 2.⊟No 3.∏.P	robably 4 Unknown
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	icien: The la certificate hes rector, page 2	ပို	25. Was case referred to medical					1□ Yes 2	No 1 ☐ Yes	2 □ No
		o B	examiner?	ospital: 1 ☐ Inpatient 2 [TER/Outpation	Othe		eath Check only one	*	
0	er thi	L L	27. Manner of Death	28a. Date of Injury (Month, Day Year)		28c. Injury Work		28d. Describe ho	nce 6 Other (Spe	icity)
0	ath. r: Aft	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? ′es 2			
DIVISION	er de racto by tr	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (Str City or Town	eet and Number or R	ural Route Number,
ב	rs eft	Ce						Only of Young	. Siate)	
	Tosp 4 hou Fune ely fil	edical	Z Medical Examin	cian: To the best of my kr	nowledge, death	occurred at the tim	e, date and plac	ce, and due to the ca	use(s) and manner as	s stated.
	To the Hospitel or Attending Phys within 24 hours elter death. To the Funersi Director: After this completely filled in by the funeral di	Med	29b. Signature and title of certifier	and manner stated.						
	2	7)	Din 11.	~ 0		29c. License		-	d. Date signed (Mont	
•	2		20 Name and office of	~ (i)	02:	1 10	011363	'	Dec 14, 2	160° (
	mas		30. Name and address of person who con	911 N2	#11 23a) (Type, F	Y LIVI	Lle ;	10 215	61	
	Sta	te	31. Date filed (Horth, Dat. Yar/2006	921 M2	nature	· N ·				
	Registra	ar	DEO T T TOOL	1.20 1	J 600	age)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Year RENE Dawn. WHITAKER 12 2006 /Medical 11:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS - BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F 196-18-3940 82 PA Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show iner must be notified at 1 Yes 2 No Director PA Bedford Hyndman 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 188 Cunningham Dr 15545 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, Black, White, etc. 1 Never Married 2 Married ö 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 ☐ Divorced "natural", White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Richard Weimer Nora Mae Howard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Eric Larson/ Son 242 Wedgewood Ln., New Paris, PA 15554 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bedford Memorial 12-20-2006 Bedford, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harvey H. Leigler Funeral Home 169 Clarence St., Hyndman, PA 15545 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Snoblen 30 minhty avoli ac /Medical Due to (or as a consequence of) Examiner Zeschion Ombolominal Ourtic omentim Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Serve ontwinsclerosis physician and s the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) as been signed by the 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? 2 No 1∐ Yes 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: s after death.

I Director: A

od in by the fu within 24 hours a

To the Funeral I

completely filled To the

death with

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Medical Certification: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 13233 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SETON DRIVE CUMBERCAND, NOD 21502 DR. Arumucham Pilai 915

State Registrar

31. Date filed (Month, Day, Year) DEC 18 2006

determined

3 ☐ Suicide

4 Homicide

32. registrar's Signature

5

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina. **Physician** /Medical Examiner Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the

Physician

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Be Completed by

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within 24 hours after death To the Funeral Director:

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Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed? Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

(Month, Day Year) 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of contifier

5 ☐ Pending investigation

6 ☐ Could not be determined

30948

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James

5 harles St. Baltimore, M. D. 6 69

31. Date filed (Month, Day, Year) State

32. Redistrar's Signature

Registrar

			1 - For State Registrar		Marylar		artmen tificat				lental Hy	Rag. N	/ 11	06	414	29
	Physici	an	Decedent's Name (First, Middle, CITZ ANNIE		,	тотсит					2. Date of De Month	D	ay	Year	3. Time of t	
	/Medic		SUZANNE 4a. Facility Name (If not institution,	KAY		WRIGHT	4h City	Town or	Location	of Death	DECEMBI		, 200 c. County		2:12	PM
	Examin	ier	UNION HOSPITAL	give on dot into	,20.7		-u. Ony,		KTON	OI DOGUI			CECI			
	Funeral				7. Age (In yrs.	last birthday)	If Under Months	1 Year	If Under	24 Hrs. Min.	8. Date of Bi (Month, Da				place (State or	Foreign
	Director		221-38-2613	1 ☐ M 2 🖾 F	5.5	Yrs.	Months	Days	Hours	Min.	JAN. 2	6, 1	951	Cou	PA	_
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation								10d. Inside City	v Limits
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	r 28e	Director	10e. Street and Number	101111		-	10f. Zip					10g. C	itizen of V	Vhat Cou	ntry?	
	23e o	aiD	1831 DIXIE LIN	E ROAD				19	702				U.S	.A.		
	r dea lems	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	I.S. 13.	Vas Deced	dent of Hi	spanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	0-		e - Ameri k, White,	can Indian,	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 Tes	2 📉 No e	i	☐ Yes				,		Specify		VHITE	
21215-0036	within 72 hours after death with the Maryland ene. than chatural, or items 23e or 28e-f show than chatter from the notified at	ed b	15. Decedent's	Year or Da	ites:	16a. Deced	lent's Usua	al Occupa	ation			16h I	Kind of Bu			
215	hin 72	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	4or 5+)	(Give	kind of wo	rk done d se retired,	luring mos)	t of work	ing	100.1	W/G 01 D0		audity	
7	filed wit Hygiene other tha	Соп	12	Conlege (1		CA	SHIE	R				DEP	ARTM	ENT	STORE	
Maryland	be file tal Hy d oth	Be	17. Father's Name (First, Middle, La	ast)							e (First, Middle		n Sumam	e)		
Z	should be nd Mental marked matic ev	^L	GLENN YINGER	. (T							NDERSO					
Z Z	d 2 st th an th an treur		19a. Informant's Name/Relationshi		D						al Route Numb NEWARI				Code)	
ē,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If filem 27 is marked other than "naturat", or items 23e or 28e-1 show it if item 27 is marked other than "naturat", or items 23e or 28e-1 show or other treumatic event. It is Madical Examiner must be notified at		20a. Method of Disposition	/ HODDAN	20b. I	Place of Dispo	sition (Nan	ne of	1		Date				own, State	
E E	Pages nent of I nnt: If it		1 ☐ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe			cemetery, cren AYERDAT				.2/09	/2006	NE	WARK	, DE		
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of usual Service Li	• •	1						ERAL HO	MES				
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			23a. Part1. Enter the disease, or shock, or heart failure. List or	omplications that can be on ba	used the dear	h. Do not ente	er the mod	e of dying	g, such as	cardiac	or respiratory a	rrest,		ľ	Approximate Interval Betw	reen
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	/Medical Examiner		resulting in death)	Due to (d	or at a consec	ve He Jenoti	. 4	1000	Ld-	C					110	
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D	iabet	Me	el, G	4.1							4000	
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ď.	The law requires that the te has been signed by th page 2 should be detache	by Pi	Part II. Dther significant condition	s contributing to dea	ath but not res	ulting in the ur	derlying ca	ause give	n in Part I.		23e. Did t	obacco	use contr	ibute to th	ne cause of de	ath?
Vital Records,	w requires that been signed to should be deta		- Kenal - Obosila	failure	2 `						10	Yes 2	□ No	3 🗌 Prob	ably 4 Dor	iknown
eco	law re as be 2 sho	Completed	- Obosila	.0							24a. Was		24b. V	Vere auto	psy findings av	vailable
		Com	/								perfo	rmed?	, d	eath?	2□ No	330 01
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Division of	ol or Attendi after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place	of Injury - At h	ome, farm, stre					28f. Location (er or Rura	l Route Numbe	er,
ā	ours afte ours afte nerel Dire	Cert	4 Homicide	buildin	g, etc. (Specif	у)					City or To	wn, Stati	9)			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel Director.	edical (29a. Certifier 1 Certifying (Check only 2 Medical Fa	Physician: To the la	pest of my kno	wiedge, death	occurred a	at the time	e, date an	d place,	and due to the	cause(s) and mar	nner as si	ated.	
	within 24 To the F complete	Medi	Une)	and manne	er stated.											
	To To	-	29b. Signature and title of certifier	P. o.l0.	- C n	<i>ι</i> λ		. License つって		22.2				(Month,	Day, Year)	
		-	20. Name and address of server in	achder		7)	(Coint)		253	122		/ 2	< · C	, 0	6	
	10		30. Name and address of person with SS SACHD TO 31. Date filed (Month, Day, Year)	EVMD,	gistrar's Signa	lost E	5+	E	PLE	m	- ND 2	19	21			ri
	Sta Registra		DEC 1. 1 2	2006	the S	A POPOL	Man)									

				f Maryland / Depa	artment of Health and Natificate of Death	lental Hygier	_	41430
	Physici /Medic Examir	cal	MARY ELIZABETH WALLS 4a. Facility Name (If not institution, give street and nu CHESTER RIVER HOSPITAL		4b. City, Town, or Location of Death CHESTERTOWN	DECEMBER 1	1, 2006 4c. County of Death	3. Time of Death 10:55 A M
	Funeral Director		5. Social Security Number 221–22–4961	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year II Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Yei 09/14/19		olace (State or Foreign htry) MD
	the Maryland 28a-f ahow actified at	ector	MD 10b. County QUEEN ANNE S 10e. Street and Number	10c. City, Town or Lo		100	Citizen of What Cour	0d. Inside City Limits 1 ☐ Yes 2 No
99	Ja within 72 hours after death with the Maryland Jiene. It than "natural", or Itame 23a or 28a-f ahow Ita Meulcal Executational Le modified at	/ Funeral Director	1605 MCGINNIS ROAD 11. Marital Status 1 Never Married 2 Amarried 1 Sec. 1 Sec. 1	edent Ever in U.S. 13. orces?	21620 Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto	U	SA 14. Race - Americ Black, White, Specify: WHI	ean Indian,
Maryland 21215-0036	within 72 hours ene. than "natural", the Medical Exe	Completed by	3 Widowed 4 Divorced Year or D 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (ates: 16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) OMEMAKER		Kind of Business/Ind	dustry
yland 2	be filed ntal Hygi nd other event, I	To Be Co	17. Father's Name (First, Middle, Last) JAMES W. JONES		MARY V	e (First, Middle, Maid IRGINIA RO	en Sumame) YER	
	Health a tem 27 la		19a. Informant's Name/Relationship (Type, Print) WILLIAM WALLS, SR./HUSB. 20a. Method of Disposition	AND 160	ng Address (Street and Number or Rur 5 MCGINNIS ROAD, (position (Name of matory or other place)	CHESTERTOW		20
Baltimore,	permit. Pages Department of Important: If It any injury or o		1 🛱 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee	CHURCH 22	HILL CEMETERY 12/02. Name and Address of Facility ELLOWS, HELFENBEIT 30 SPEER ROAD, CHI	J AND NEWN	AM FIINERAI	
	Physician /Medical Examiner		resulting in death)	aused the death. Do not en			TID 21020	Approximate Interval Between Onset and Death
68760,	cate be executed physician and the burial-transit	dical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of):				
P.O. Box 6	The law requires that the death certificat tie has been signed by the ettending phy tage 2 should be detached for use as the	Physician/Med	in the past 12 months?	ant at time of death 5	Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	Pry Day Year
	w requires that been signed b should be deta	ompleted by PI	Part II. Other significant conditions contributing to d	eath but not resulting in the u				ne cause of death? ably 4 Unknown
Vital Records,	Phyeicien: The lav this certificate has ral director, page 2	BeC	25. Was case referred to medical examiner?		Other	autopsy performed: 1 Yes 221 h (Check only one)	prior to col death? To 1 Yes	npletion of cause of
Division of	e le	Certification; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	th, Day Year) Injury	I 28c. Injury at Work? M 1 Yes 2 No	me 5 ☐ Residence 28d. Describe how in	jury occurred	
Divi	To the Hospital or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Certifi	4 Homicide determined 289. Place build	of Injury - At home, farm, sting, etc. (Specify) best of my knowledge, deat asis of examination and/or in	reet, factory, office h occurred at the time, date and place, vestigation, in my opinion, death occur	28f. Location (Street City or Town, Sta	ate)	dated.
)	To the h within 24 To the F complete	Medi	29b. Signature and title of certifier	mer stated.	29c. License number	29d. [Date signed (Month,	Day, Year)
	2.0		30. Name and address of person the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the cause of the complete cause of the complete cause of the complete cause of the cause of t	se of death (Item 23a) (Type, W.) 100 - 100 S K Ggistrar's Signature	Print) PD STOJ	Charle	nTour	, my decy
	Sta Registr		DEC 0 6 2006	some & A	north			

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day MATTHEW YOUNG 2006 RICHARD DECEMBER /Medical 6 6:15 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CLINTON NURSING & REHABILITION CNT CLINTON PRINCE GEORGE'S 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, AUG. 9 **Funeral** Birthplace (State or Foreign Country) Months Days Min 1 MM 2 □ F Hours Director 235-36-7849 80 1926 WEST VIRGINIA Usual Residence of Decedent the Maryland 10a State "naturel", or iteme 23a or 28a-f show salesi Examinar musike politica at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No PRINCE GEORGE'S FT. WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20744 U.S.A. 2802 ROSE VALLEY DRIVE Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene.
ant: If Item 27 is marked other then "naturel", or Iter ury or other traumatic event, the Medical Evant and Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th MILITARY POLICE OFFICER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RICHARD YOUNG WILSIE CLARK ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2802 ROSE VALLEY DRIVE FT. WASHINGTON, MARYLAND 20744 ESTELLA YOUNG/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 23 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: if eny injury or goost. 4 □ Donation 5 □ Other (Specify) 12/12/2006 ARLINGTON, VIRGINIA ARLINGTON NATIONAL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final/disease or condition resulting in death) MYELODYSPLASTIC SYNDROME **Physician** /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the eld be detected for 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PANCYTOPENIA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen CHRONIC KIDNEY FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? res 2 2 No HYPOTHYROIDISM 1 ☐ Yes 2 No 1 Yes or Attending Physicien: after death. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 M Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ٩ ierel Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medi To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING PHYSICIAN D52900 DECEMBER 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUSA MOMOH M.D. 8700 CENTRAL AVENUE # 301 LANDOVER, MARYLAND 20785 31. Date filed (Month, Day, Year)
DEC 1 2 2006 32. Registrar's Signature State Registrar

			1 - For Stete Registrer	State of Maryland / D	epartment of Health and Certificate of Death	and Mental Hygie	0
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) FRURGE 4a. Facility Name (If not institution, give: RALLIMORE VA N		Yeakle 4b. Giv. Town, or Location Baltimore	2. Date of Death Month /2 of Death	Day Year 3. Time of Death 2006 14:12 M 4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birth			9 Birthplace (State or Foreign
	hours after death with the Maryland turel', or Items 23a or 28e-1 show al Examinar must be notified at	ector	MD 10a. State 10b. County Washing 10b. Street and Number	ton Big			10d. Inside City Limits 1 ☐ Yes 2♥No
	r death with	Completed by Funeral Director	11425 Big Poo.	2. Was Decedent Ever in U.S.	21711 13. Was Decedent of Hispanic Ori		J. Citizen of What Country? U.S.A. 14. Race - American Indian,
21215-0036	72 hours afteneursul, or it	ted by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edur	197 Yes 2 No 1948 — If Yes, Give Year or Dates: 1949	1 ☐ Yes 2 ☐XNo Specify:	1.6	Black, White, etc. Specify: White b. Kind of Business/Industry
12121	filed within 7 Hygiene. Ither then "n		(Specify only highest grade Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Give kind of work done during mos life. DO NOT use retired) Carman	t of working	railroad
Maryland	should be tand Mental I	To Be	John Theodore 19a. Informant's Name/Relationship (Ty)			or's Name (First, Middle, Ma Ssie Ethel or or Rural Route Number, C	O'Conner
	Pages 1 end 2 nent of Health a nnt: If Item 27 is ury or other tre		Una Mae Yeakle 20a. Method of Disposition 1 Serial 2 Cremation 3 R	wife 11	1425 Big Pool Disposition (Name of crematory or other place)	Rd Big Poo	l, MD 21711 c. Location - City or Town, State lear Spring, MD
Baltimore,	permit. Pa Departmen Important: eny injury once.		4 Donation 5 Other (Specify) 21. Signifure of Funeral Specifics	J	ol Cemetery 22. Name and Address of Facilit Donald Edwin	Thompson F	uneral Home,Inc
1	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do no e cause on each line.	t enter the mode of dying, such as SMALL B	cardiac or respiratory arrest	Approximate
	w requires that the death certificate be executed be seed to the standing physicien and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or riqury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of	:	ALL BOW	eL 16 days
P.O. Box 68	Attending Physician: The law requires that the death certifica rideath. rideath. etter: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Records, P	equires that sen signed b tould be deta	þ	Part II. Other significent conditions con	ributing to death but not resulting in the	ne underlying cause given in Part I. \mathcal{NOMA}	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of death? 2
tal Rec	n: The law fficate has b or, page 2 st	Completed	25. Was case referred to medical			24a. Was an autopsy penormed 1 ☐ Yes 2 ☑	
>	ysicia s cert direct	To Be	examiner?	ospital: 1 Inpatient 2 ER/Outp	1 000	of Death (Check only one)	
פֿ	ig Ph ter thi heral (ı.	27. Manner of Death	28a. Date of Injury 28b. Tim	ne of 28c. Injury at	sing Home 5 Residence	
Ö	endin sath. or: Af he fur	atlo	1	(Month, Day Year) Inju	M 1 ☐ Yes 2 ☐ N	lo	
Division of Vital	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funerel Director: Atten this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)		City or Town, S	,
	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in the Funeral Director Completely filled in the Completely fill	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physi 2 ☐ Medical Examin 29b. Signature and little of certifier	cien: To the best of my knowledge, or: On the basis of examination and/or and manner stated.	leath occurred at the time, date and or investigation, in my opinion, death	occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)
	r > F 0		30. Name and address of person who co	plet at cause of death (Item 23a) (Ty		/	EC 12 2006 MORE, MD 21201
5/	1-10+1		Anil Kashyo	XP.	ION GREENCS	treat BALL.	MORE MD 21201
4	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1.11		

			1 - State of Maryland / Department	artment of Health and M tificate of Death		ene g. n.2006 41433
			Decedent's Name (First, Middle, Last)	·	2. Date of Death	3. Time of Death
	Physici /Medi		Yvonne White		Month Pa	Day Year 810 A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			1400 A Golden Rock Court	Bel Camp		Harford
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 ♥ F Q ∩ Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	
	Director		217-50-3347		Aug 2, 1	916 Maryland
	yland		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	Mar History	tor	MD Harford Bel C	amp		1 ☐ Yes 2 ☐ No
	th the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	23e	ai	1400 A Golden Rock Court	21017		USA
	er de	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Amed Forces?	Vas Decedent of Hispanic Origin? (Spi Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	hours after death with the Maryland turel; or Items 23e or 28e-f ehow A Exer's retrigat by rediffied at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	☐ Yes 2∏ No Specify:		Specify: white
9	id within 72 hours a giane er than "neturel", c			ent's Usual Occupation	11	6b. Kind of Business/Industry
215	within 72 ene. than "nel	Completed	(Specify only highest grade completed) (Give	kind of work done during most of works OO NOT use retired)	ing	ob. Kild of business/industry
21	d with giene er the	mo:		nousewife		own home
멀	oth o	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name		
<u>ya</u>	should be ind Mental s marked o umetic eve	70	John Heinz	Ruth Dr	essell	
Maryland 21215-0036	an an an	o: l		g Address (Street and Number or Rura		
	s 1 and if Health item 27 other tr	1 /		Churchville Road		
Baltimore,	0 = 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State '4 ☒ Donation 5 □ Other (Specify)	natory or other place)	Date 20	Oc. Location - City or Town, State
Ball	permit. Pag Department Importent: any injury o		St. Wade, Arector St	Name and Address of Facility ate Anatomy Board 1timore, MD 21201		Baltimore Street
	Pinysician		28a. Part. Enter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	or the mode of dying, such as cardiac c		t, Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
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8760, %	ficate be executed physician and s the burial-transit	i Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
687	ficate t physics to the b	edicai	d.			
.O. Box	that the death certific ed by the attending p detached for use as i	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
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00	w requir been si should	lete			24a. Was an	24b. Were autopsy findings available
Vital Records,		Completed			autopsy performe	prior to completion of cause of
	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1x Yes 2 No	26. Place of Death Other: 4 T Nursing Hon		
	g Phys er this eral dii	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 2	ne 5 💢 Hesidend 18d. Describe how	ce 6 Other (Specify)
<u>o</u>	Attending I or death. ector: After by the funer.	atio	Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division	after death after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, stree building, etc. (Specify)	et, factory, office	8f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death and manner stated. 29a. Certifier (Check only one)	occurred at the time, date and place, a sstigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
			Memarl & Giller UM MIF	10014206	M	co. le 18 2006
	10	-	30. Name and address of person who completed cause of death (Item 23a) (Type, F	DOO14206 UKCHVILLE ROAD	RELAID L	1d 710/5
	Sta Registra		31. Date filed (Month, Day, Year) DEC 2 7 2006 32. Registrar's Signature	who were the same of the same	V-~ '11\\ "	W < 100 >

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 23,2006 MARJORIE CAUSEY **ABELI** 4:22A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | October 4, 1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M XXX Months Days 216-28-7822 Mary Tand 76 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2/17/No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 Midhurst Road 21212 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 V No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tes 2 If Yes, Give Year or Dates: 1 ☐ Yes XXNo Specify: 3XWidowed 4 □ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Winfeild Causey Katharine Luckett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward S Abell Son 7017 Kenleigh Road Baltimore, Maryland 21212 Method of Disposition AD Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 12/28/06 Pikesville Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 YOrk Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)) ement ears Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 7 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

la or 28a-f show t be notified at

or items

"natural", or ite⊓ edical Examiner

the Medical

.. Pages 1 and 2 should be filed wit tment of Health and Mental Hygien tant: If item 27 is marked other th ijury or other traumatic event, the

permit. Page Department o Important: If any injury or once.

Director

Funeral

Be Completed by

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filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician for use as the buria cate has been signed by page 2 should be detact certificate After this

the burial-tran as within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

Physician/Medical Completed by Be 은

Examiner

Certification:

Medical

1 DNatural

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

(Check only one)

31. Date filed (Month

Registrar

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

025205

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) December 24, 2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Belts und 21207

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760

Physician /Medical Examiner law requires that the death certificate be executed physician and s the burial-transit signed by page certificate Hospital or Attending Physician: 124 hours after death.

• Funeral Director: A pletely filled in by the fu within 2 To the

Physician

/Medical

Examiner

10a. State

Funeral

Director

3a or 28a-f show t be notified at

Department of Health and Mental Hygiene."
Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must Equine.

Director

Funeral

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Completed

within 72 hours after death with the Maryland

Pages 1 and 2 should be

	20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐ P	James val fram State	20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City of Company C							Town, State
	4 □ Donation 5 □ Other (Specify)		DRUID	RID	GE	12.30	ماO . (PIKE	SVILLE	MD
	21. Sign ture of Funeral Service Licens	ee)		22. Na VAV 5151	me and Address of F BHN C. G BALTO. NA	acility REENE ATC PI	FUNE KE BO	RAL S	SERVICE MD 2	E 1229
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ertific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injur building, etc.	y - At home, far (Specify)	rm, street, f	actory, office	1	28f. Location City or To	(Street and own, State)	Number or R	ural Route Number,
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Me	29b. Signature and title of certifier				29c. License numb	per		29d. Date	signed (Mon	th, Day, Year)
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	30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) (Type, Print)				/	7	
ate	IMRAN SIDDIQI, 31. Date filed (Month, Day, Year)	32 Pagietras		LER	DRIVE, T	OWSON	, MAR	RYLAN	D 212	Ø14
rar	31. Date filed (Month, Day, Year) DEC 2 8 200	6 felle sure	20.							
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For Amend #18 Per State of Maryland Department of Health and Mental Hygiene 2 1 1 6862 12/28/06 The Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Elizabeth Ann Abraham 1309 as06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SHIBAIN Wicomico PENINSULA REGIONOR Medicon If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 021-46-8973 **Funeral** 1 ☐ M 2 😿 F Months 52 02/10/1954 Director Worcester, MA Usual Residence of Decedent Baltimore, Maryland 21215-0036 filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at MD Wicomico Delmar 1 ☐ Yes 2 XNo by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 31309 21875 Carioca Road USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Cook's Assistant Nursing Home 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Abraham J. Briam M Catherine Maleskas Charles K. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 68 Vale Street, Worcester, MA 01604 Leseman / Aunt Anna 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rural Cemetery and 20c. Location - City or Town, State 20a. Method of Disposition 12/30/2006 permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Buriał 2 ☐ Cremation 3 ☐ Removal from State Worcester, MA 4 Donation 5 Other (Specify) Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Avenue, Baltimore, M Marshall W. Mairie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEAR **Physician** DISEASO COMONANT ANTELY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes been signed by the should be detached 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown DIABETTS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHRONIC PENAC 24a. Was an autopsy performed? Yes 2 No page 2 E PEBELLIN 1□ Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 029168 Ree 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIVISION 500 ROBERT ALLEN M.O. SALISBULY MD. 21804 34. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/200

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Examiner	4	a. Facility Name (If not institution, giv		1		r Location of Deat Sadena	h	4c. County of		[ab	
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Funeral Director	- 1		□M 213 F	59 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Feb. 10	1947	Count	MD MD	
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Se-f	3		Arundel	1		adena		og. Citizen of W	Ibat Count		- 424
Pen Dir	5	10e. Street and Number 8466 Bedford Road	4		10f. Zip Code	21122			SA	ıy:	
ns 23	5	1. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H		Specify Yes or No-	14. Race	- America		
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	2	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces' 1 Yes 2 Yes If Yes, Give Year or Dates:	No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puer Specify:	to Rican, etc.)	Specify:	k, White, e	nite	
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State Registrar		30. Name and address of person was 31. Date filed (Month, Day, Year)	1ccm4	death (Item 23a) (Type	Print) Agu	hart	- Necia	Max.	is by	12/06	17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year BANDELL GORDON **Physician** 26, 2006 Lecember /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MEMOTIAL 7. Age (In yrs. last birthday) BAltIMOSE MUNION If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F 212-01-5463 Many/AN Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r than "natural", or itama 23a or 28a-f ahow the Medical Examinar must be notified at BAHIMICE 1 Yes 2 No Director MARY/AND 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4.5 4338 HUZNUC Newpor 21211 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 12Yes 2 No
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Year or Dates: Army 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: WhIte Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working (life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) WArehouseman MONTEBELLO permit. Pages 1 and 2 should be filed w Depertment of Health end Mental Hygier Important: If Itam 27 Ia marked other It any injury or other traumatic avant, ILA QDGB. 12 18. Mother's Name (First, Middle, Maiden Surname) Wirk in Own 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4338 Newport BATE HD 2/211

20c. Location - City or Town, State Doris MAC Kelbrugh - Comprasion Auc 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1

■ Burial 2 □ Cremation JAN3, 2007 OWINGS, MILLS MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility TNN INC LICENS 2D MOILT COINT Charles 5 Nighland Aue Balto MD 21224 21. Signature of Funeral Service Licensee complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Sox 68760, < Due to (or as a consequence of): Medical Certification; To Be Completed by Physician/Medical 10 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 Û No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours effer death.

To the Funeral Director: A completaly filled in by the fu 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tife of certifier D0061187 26 anapathr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Ganapath

31. Date filed (Month, Day, Yeer)

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32. Registrar's Signature

Memorial Hospital

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a	icien: The l certificate ha ector, page	e Co	deneuba									2010	death? 1 ☐ Yes	2□ No		
₹		o Be	25. Was case referred to medical examiner?	Hospital:	inet 2 🗆	ER/Outpatient	3 □ DO	A Othe			Check onl o		704			
of	ig Physter this	\vdash	27. Manner of Death	28a. Date of In	jury	28b. Time of		8c. Injury Work	4 LINIU		ne 5 🗆 Resid			uty)		
io	블로돌	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, E	ay rear)	Injury	М		7 ′es 2 🗆 1	No						
Division	ter de irecto	ertification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of I	njury - At ho	ome, farm, stre	et, factory	, office		2	8f. Location (S City or Tow		Number or Ru	ral Route h	lumber,	
Ω	urs aft	0									-					
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edicai	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the bes miner: On the basis and manner:	of examina	wiedge, death tion and/or inv	occurred a estigation,	at the time in my op	e, date and inion, deat	d place, a th occurre	nd due to the old at the time, o	ause(s) a date and p	nd manner as lace, and due	stated. to the caus	se(s)	
	o the vithin of the omple	Mec	29b. Signature and title of certifier	and manner s	stated.		29c.	. License	number			29d. Date	signed (Month	ı. Dav. Yea	r)	
}	- s + ö			evanus			T	119	66	7			24-20			
			30. Name and address of person wh	completed cause of	death (Item	1 23a) (Type, F	Print) .	ノ <u>、</u> ・								
1	0		Schrael Suresa	12 to 73	310	Pitch	11/	Musc	my "	208	3 Gleu	Born	er, Vid	5101	10	
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ture	- 4		0							
	Registr	ar	DEC 287	006	12,5	1 Sol	MI									

			1 - State Amend #8 Per	State of Mary	land Dep 04/07 Ce	artment <i>rtificate</i>	of H	ealth a Death	nd M		ene2 () () 6 g. No.	
	Dhyoisi		1. Decedent's Name (First, Middle, Last)							2. Date of Death Month		3. Time of Death
	Physici /Medio			aker							23, 2006	12:10p M
	Examin	er	4a. Facility Name (If not institution, give s		1			Location of			4c. County of Dea	
	Funeval		South River Hea 5. Social Security Number 6. Sec		a D yrs. last birthday)		_	vater If Under 24		8. Date of Birth	Anne Ar	
	Funeral Director			(M 2□F 82			Days	Hours	Min.	Sept 7	924 9 50 1 926 Mar	thplace (State or Foreign ountry)
	P .		Usual Residence of Decedent			1				осре 7	1720 1141	y tand
	ehov	2	10a. State 10b. County		c. City, Town or Lo							10d. Inside City Limits
	28a-1	ecto	Maryland Anne Aru 10e. Street and Number	ndel G	len Burn) and a			40	000	1 ☐ Yes 25€No
	with Se or	ā	236 Brentwood Cour	+		10f. Zip C		21061		10	g. Citizen of What Co USA	ountry?
	death	Funeral Director		12. Was Decedent Ever	in U.S. 13.	Was Decede			in? (Spec	cify Yes or No- Rican, etc.)	14. Race - Ame	nican Indian.
ထ္	after or its	Fui	1 Never Married 2 Married	Armed Forces? 1X∫Yes 2 ☐ No If Yes, Give		If Yes, specify 1 Yes 2			Puerto F	Rican, etc.)	Black, Whit	
8	2 should be filed within 72 hours after death with the Maryland and Mentel Hygiene. and Mentel Hygiene and Mentel Hygiene is marked other than "natural", or iteme 23e or 28e-f ehow eumatic event, In a Marical Examinar must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:				ur' mané			Specify: Wh	1te
Maryland 21215-0036	n 72 I	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupat	tion uring most o	of workin	19	6b. Kind of Business	Industry
212	iene.	ошь	Elementary/Secondary (0-12)	College (1-4or 5+)		oreman					Millwork	
פ	e filec Il Hyg othe	Bec	17. Father's Name (First, Middle, Last)	<u> </u>		OI CIIIdii		18. Mother's	s Name	(First, Middle, Ma		
<u>la</u>	should be Ind Mental I	ToE	William Baker					Marg	gare	t Griff	in	
lan	s 1 and 2 should of Heelth and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type								City or Town, State, 2	
<u>ح</u> ق	t and theelth om 27 in the tr		Sue A. Skierkowski					Court		-	e, Maryla	
و	Pages nent of thint: If its iry or of		20a. Method of Disposition	emoval from State	Ob. Place of Dispo cemetery, crei	matory or other	er place	1			Oc. Location - City or	
Baltimore,			4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		edar Hil	1 Ceme			2/28	/06 B	rooklyn P	ark, MD.
n H	permit. Departr Importr eny inj		A STATE OF THE STA	11/	Mc	Cully-	Pol:	yniak	Fun	eral _p Hom	e P.A. imore, Md	. 21225
			23a. Part1 Enter the disease, or complice shock, or heart failure. List only on	cations that caused the	death. Do not ent	37 Eas	t Pa	atapso , such as ca	CO A	respiratory arres	t,	Approximate
	Pnysician		Immediate Cause (Final disease or condition	Caroli	no f	mil.	6	n/:			-	Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a cor	rsequence of)	1	VYN					
	Examiner		Sequentially list conditions, b	Tall	leve 10	Av	No					
	led sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	rsequence of):							
	al-trar	xan	that initiated events c.	. Due to (or as a cor	nsequence of):		-					
2/PU	ate be executed thysician and the burial-transit	dical	L _d									
٥		Medi										
X Q Q	th certendir	an/h	200. Was decedent program	3c. If yes, outcome of pro 1 ☐ Live birth 2 ☐	egnancy Fetal death 3	Ectopic preg	nancv				23d. Date of deli	very
	ne death the atter hed for u	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown		Other (spec					Month	Day Year
Ţ.	requires that the		Part II. Other significant conditions conf	tributing to death but not	resulting in the u	nderhing cau	eo awar	in Part I		22a Did toba	cco use contribute to	the serves of death?
cords,	ures sign d be	d by	Deuter		and an area are	isonymy out.	JO GIVEI	initiani.			2 ☐ No 3 ☐ Pro	
	w req	ompleted							_	24a. Was an		-
Ē	The law ete hes b page 2 st	ошо							_	autopsy performe	prior to death?	topsy findings available ompletion of cause of
N I G	tan: rtifice stor, p	C	25. Was case referred to medical					26 Place of	f Death /	Check only one	ĨNo 1 ☐ Yes	2 No
>	hysic his ce I direc	ToB	examiner?	ospital: 1 Inpatient	2 🗍 ER/Outpatien	t 3 DOA	Other		-	1 - 10 - 11	ce 6 Other (Spec	ufy)
5	Ing P		27. Mann	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c	Injury a			3d. Describe how		
2	ttend death ttor: /	cati	2 Accident investigation 3 Suicide 6 Could not be			М		s 2 No		•		
DIVISION	after Direc	ertification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str pecify)	eet, factory, o	ffice		28	St. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
-	S 40 00	OL	29a. Certifier (Certifying Physi	ician: To the best of my	knowledge, death	occurred at 1	he time	, date and r	place, an	nd due to the caus	se(s) and manner as	stated.
	n 24 t n 24 t he Fu oletely	edicai	(Check only 2 Medical Examin	er: On the basis of examand manner stated.	nination and/or inv	estigation, in	my opir	nion, death	occurred	at the time, date	and place, and due	to the cause(s)
	To t Com	Σ	29b. Signature and title of ertifier				icense r		~	29d	. Date signed (Monti	, Day, Year)
	\		1				57	028	5	1	2-27.	06
1			30. Name and address of person who con	npleted cause of death	(Item, 23a) (Type,	Print)	701	Along	an	alic N	11) 011	51
	Stat	e	31. Date filed (Month, Day, Year)	32 Registrar's \$	ignature ignature	C.TT/	0	1/11/	MA	VIID IV	11 214	<u> </u>
	Registra		DEC 2, 8, 2008		M. Ass	aki b			•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 16:30 AM EliZA BETA UHW. /Medical 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WAR BASH NIA BALHORE If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 T Yrs. Director 9368 79 22 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits la or 28a-f sho t be notified a 1 Stes 2 No Director Baltikeen MAYLOND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 ral", or items 23a Examiner must b U513 3625 WABASH by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3/0.016 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Oun Hosat Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene Important: If Item 27 Is marked other than any Injury or other traumatic event, the M HOUSE CANK 01300 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Whitner WILL MAVIO martin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORETHEA MERIDEAC BaltiHore, Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State Randallstown Md 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park Con. 12-29-66
22. Name and Address of Facility 21. Signature of Funeral Service Mensee Med 2121. BALKAGE CHATHAN-HAMI KNEW 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to r as a consequence of): anemia /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No 9☐Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 🔲 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director; After this or completely filled in by the funeral dire 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar messent

Merrangera

DEC 2 8 2006

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

2. Registrar's Signature

DHMH 17 Rev 1/2001

market

151260

December 27, 2006

Please T	Type or Print in Black			•	•	
For State Registrar	State of Maryland /	Department of F Certificate of		lental Hygier _{Reg. t}		1110
Decedent's Name (First, Middle, Last)	,			2. Date of Death	Z U U D 3. T	ime of Death
NORMAN M	EREDITH BULL, SI	R		December	^{Day} 20, 2006 8	8:50 A M
4a. Facility Name (If not institution, give s			or Location of Death	·	4c. County of Death	. 50 11
STELLA MARIS HOS		Timoni			Baltimore Co	intv
5. Social Security Number 6. Sex	№ 2□ F	birthday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	ar) 9. Birthplace (5 Country)	State or Foreign
179-20-8407 Usual Residence of Decedent	X ^{™ 2□ F} 79	Yrs.			1927 Pennsy	lvania
10a. State 10b. County	10c. City, To	own or Location			10d. Ins	side City Limits
Maryland Baltimore	County	Timonium				□Yes 2∏No
10e. Street and Number	2 COURTLY 1	10f. Zip Code		10g. /	Citizen of What Country?	
2300 Dulaney Vall	lev Road		21093		USA	
	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indi	ian,
1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 XYes 2 □ No WWII If Yes, Give	T If Yes, specify Cuba	oan, Mexican, Puerto i	Rican, etc.)	Black, White, etc.	
3 XWidowed 4 ☐ Divorced	Year or Dates:	1 ☐ Yes 2 XNo	Specify:	_	Specify: White	
15. Decedent's Educ (Specify only highest grade	cation 16: e completed)	6a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	pation during most of worki	ina 16b.	. Kind of Business/Industry	
Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired		(Construction	
17. Father's Name (First, Middle, Last)				e (First, Middle, Maid	,	
James Thomas	Bul1		Sybi1		Ludwig	
19a. Informant's Name/Relationship (Typ		9b. Mailing Address (Street				
Amanda Ellen Bull 20a. Method of Disposition 1 X Burial 2 Cremation 3 Re	20b. Place cemet	4 Dunhaven P1 of Disposition (Name of tery, crematory or other place	ice)	Date 20c.	am, Maryland Location - City or Town, Sta	tate
4 Donation 5 Other (Specify)	St. M	Mary's Ch Cem	a 12/22	./2006 Ba	ltimore, Mary	vland
	wson wson	6500 York	Wiedefeld Road, Ba	l Funeral I Itimore, I	Home, Inc. Maryland 2121	
23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death. Do				Appro Interv	oximate val Between
Immediate Cause (Final disease or condition	CEREBROVASCULA	AD ACCIDENT			Onset	et and Death
resulting in death)	Due to (or as a consequence					
h		,				
Sequentially list conditions, if any, leading to immediate cause. Enter University	Due to (or as a consequence	e of):				
Cause. Enter Underlying Cause (Disease or injury that initiated events coulding in devents c.						
resulting in death) Last	Due to (or as a consequence	a of):				
d	l					
IF FEMALE;						
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown		4		23d. Date of delivery Month Day	Year
Part II. Other significant conditions conf	atributing to death but not resulting	in the underlying cause giv	on in Part I	23a Did tobacc	o use contribute to the caus	- af dooth?
	albumy to demine	III tilo diracinyg	eli ili i Gici.	1 ☐ Yes		
				1		4 Dunknown
				24a. Was an autopsy	24b. Were autopsy find prior to completion	dings available on of cause of
				performed? 1□ Yes 2 X N	death?	
25. Was case referred to medical examiner?		Oth	26. Place of Death			
1 ☐ Yes 2 🙀 No	lospital: 1 Inpatient 2 ER/O		+ LI Italiang Hon		6 TOther (Specify) HC	SPICE
27. Manner of Death 1 ▼ Natural 5 Pending		o. Time of 28c. Injury Work	ry at 2 rk?	28d. Describe how inj		
2 Accident investigation 3 Suicide 6 Could not be	At Name		Yes 2 □ No			
4 Homicide determined	28e. Place of injury - At home, for building, etc. (Specify)	arm, street, factory, office	2	28f. Location (Street a City or Town, Sta	and Number or Rural Route ate)	Number,
S C. Alf. Ing Dive	- · · · · · · · · · · · · · · · · · · ·	J - A 41c - 42				
29a. Certifier (Check only one)	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	je, death occurred at the tin and/or investigation, in my o	ne, date and place, a	and due to the cause ed at the time, date a	(s) and manner as stated. and place, and due to the ca	iuse(s)
29b. Signature and title of certifier		29c. License		29d. D	Date signed (Month, Day, Ye	ear)
1		17)4	3725		12/20/06	
30. Name and address of person who cor	mpleted cause of death (Item 23a)				, , , , , , , , , , , , , , , , , , , ,	
DR. TARIQ MAHMOOD	2300 DULANEY V	/ALLEY RD. T	TIMONIUM, I	MD 21093		
31. Date filed (Month, Day, Year)	32. Registrar's Signature	Ancill 1	- Marine III	<u> </u>		
DEC 2 8 20	006 Mayer St	ANDRES				

State

Registrar

06-09745

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ymond Brezr		State of Maryland / Departme 1- For State Certifica Registrar 1. Decedent's Name (First, Middle,Last)	nt of Health and Mental H	ygiene Reg. 2. Date of Death	No. 200	5 4 4 4
Physici edical Exam		Raymond John Brezna			Day Year 21 2006	3. Time of Death 1820 hrs
		4a Facility Name (if not institution, give street and number) 1119 Revolution Street	4b. City, Town, or Location of Death Havre de Grace		4c. County of Death	<u> </u>
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 215-78-4906 1) 4 PM 2 F 32	day) If Under 1 Year If Under 24Hrs Months Days Hours Min	_	TEOROLO	thplace (State or gn untryMD
Maryland 28a-f show any d at once.	٦٢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Harford Havre	de Grace			10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e Street and Number 1119 Revolution Street	10f. Zip Code 21078	-	Citizen of What Cou SA	ntry?
ter death wi	/ Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto Yes 2 No specify: 		14. Race - Amer White, etc. Specify:	can Indian, Black, te
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours af Department of Health and Memal Hygiene. Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examin	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	ecedent's Usual Occupation (Give kind of v uring most of working life. DO NOT use reti		6b Kind of Business/	
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than c event, the Medical	Be Com	17. Father's Name (First, Middle, Last) James J. Brezna	18.Mother's Name	(First, Middle, Ma nn Homi	iden Surname)	
imore, MD 2121. Pages I and 2 should be fit nent of Heath and Mennal I ant: If item 27 is marked or other traumatic event,	2	Vickie Brezna/sister 70	Mailing Address (Street and Number or F O3 Giles St. Havre Disposition (Name of cemetery,	e de Gr		21078
Baltimore, MD Department of Health and Important: If item 27 is injury or other traumati		1 Burial 2 Cremation 3 Removal from State cremator	y or other place) 12, Deake Crematory 22. Name and Address of Facility 87	/26/06	Beltsvil:	le, MD
Balt permit Departi Import		() Q / MO1356	Cremation & Fund	eral Al	ternativ	
Physician /Medical 5xaminer	Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	cation (trazedone, oxyco Iromorphine hydromorphon	dono mo l		Approximate Interval Between Onset and Death
executed an and al - transit	Medical Exa	events resulting in death) Last Due to (or as a consequence of): d. X UNPENDED X AMENDED #23a, perMF,	2866, 4/3/07 TT , perME, g863, 1/11/07 T	· · · · · · · · · · · · · · · · · · ·		
Box 68760, e death certificate be executed the attending physician and ed for use as the burnal - transi	Physician/Med	#23a, 27, 28a-1 #23a, 27, 28a-1 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pregna Other (Specify)		23d. Date of delivery Month	Day Year
, P.O. E	þ	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		cco use contribute to	the cause of death?
Records The law requi cate has been page 2 should	Completed			24a. Was an autopsy performe	prior to o	topsy findings available ompletion of cause of
n of Vital Recling Physician: The After this certificate funeral director, page	To Be	Tes Z No			esidence 6 🗸 Other	: Scene
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death To the Funeral Director: After this certificate has been signed by the attendence ompletely filled in by the funeral director, page 2 should be detached for a	Certification:	Pending Accident Accident Suicide Suicide Pending Investigation Find 12/21/2006 Find (28e. Place of Injury - At home, farr	1 Yes 2 No	or Town, State	e) 1119 Revol	ral Route Number, City Lution Street
Divisior To the Hospital or Attenct within 24 hours after death To the Funeral Director: completely filled in by the	Medical Cer	4 Homicide determined (Specify) residence 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.		Havre de (due to the cause(s	Srace, MD s) and manner as state	ed
F 1 1 3	Me	29b. Signature and title of certifier Thousand M. King JR. M. V.	29c License number O.C.M.E.		9d. Date signed <i>(Mor</i> December 22, 20	, , ,
10 Tak			er 111 Penn Street, Baltimore	e, MD 21201		
S Regis		31. Date filed (Month, Day, Year) DEC 2 8 2006	ante			
IMH 17 Rev 1/2	001	ORIC	SINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PM :05 2006 December 25 /Medical Facility Name (It not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner X. Age (In yrs. last birthday, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 □ 4.40 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race 11. Marital Status - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: δ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Busines Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Sremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) em 21. Signature of Funeral Service Licensee Stes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic Cancer 2 years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3☐ Probably Completed 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 \subseteq Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပို this 6 Mother (Specify) + 05 p 1 + a 5 Residence Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 2 Accident 1 Tes 2 🗆 No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 To the Funeral Director: completely filled in by the 24 hours after within 2 To the

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

vel-

31. Date filed (M

Tomas Mr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Union Memorial

32. Registrar's Signature

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

AT2438946

Hospital

29d. Date signed (Month, Day, Year)

2006

		•	1 - For State Registrar	State of Mary	•	artment o			lental Hy	giene Rag. No.	2006	4 4 4 6
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Margaret 4a. Facility Name (If not institution, give s			4b. City, Tow	Lana vn, or Location	of Death	2. Date of De Month Decembe	Day Zu	Year 2006 County of Death	3. Time of Death 20: 09 pm
	Funeral Director		The Johns Hopkins 5. Social Security Number 166-42-6011 Usual Residence of Decedent		yrs. last birthday) 57 Yrs.	13al hy If Under 1 Y Months Da		r 24 Hrs. Min.	8. Date of Bit (Month, Da 09/22/	rth ay, Year) 1949	Cou	place (State or Foreign ntry) PA
	he Maryland 8a-f ehow	ector	10a. State PA 10b. County Philadel		c. City, Town or Lo	adelphi				10a Citiz	en of What Cou	10d. Inside City Limits 1 XYes 2 No
036	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other then "natural", or Iteme 23e or 28e-f ehow imatic event, the Madical Exercises must be collified at	by Funeral Director	10e. Street and Number 3531 Gloucester 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Lane 2. Was Decedent Ever Armed Forces? 1	1		19114 of Hispanic O Cuban, Mexica		ecify Yes or No Rican, etc.)	o- 1	USA 4. Race - Ameri Black, White,	can Indian,
Maryland 21215-0036	filed within 72 ho Hygiene. other then "natur ent, the Mydical	• Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)		(Give	dent's Usual O kind of work d DO NOT use re ublic R	one during mo etired) elation	ns	ing a (First, Middle	Med	d of Business/Ir ical Mi Sisters Sumame)	•
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Baltimore, M	nit. Pages 1 and 2 should estment of Health and Mer ortent: If Item 27 Ie marke injury or other traumatic 8.		Yoram Buhdana / 20a. Method of Disposition 1 Burial 2 Cremation 3	2	20b. Place of Dispo	esition (Name of matory or other 11Chre	of place)		Date	20c. Loc	ia, PA cation - City or To adelphi	own, State
Baltı	permit. Pages Depertment of Importent: If I eny injury or once.		21. Signature of Funeral Service License	Dorota W.	Marchall'	Name and A	ddress of Faci	lity		l Hom Itimo	e Inc. re, MD	21230
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	Myelogan posequencedi): Failure	3			or respiratory a	irrest,		Approximate Interval Between Onset and Death 2 years 2 week
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Division of V	Phys this al di	Certification; To	1 Yes 2 No	28a. Date of Injury (Month, Day Yes) 28e. Place of Injury building, etc. (3	- At home, farm, st	f 28c.	Injury at Work?]No	28d. Describe	how injury	Number or Run	fy) al Route Number,
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DHMH 17 Rev 1/2001

06-09672 Russell Barnes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2006 41447

		1- For State Registrar										1 1 1 1	
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birtho	day)	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. D	Date of Birth	(MM/DD/YYYY)	Birthp Foreign	lace (State or
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2121 hould be fill and Mental F is marked tite event, t		19a. Informant's Name/Relations	ship (Type, Print)	Father			Address (Street						ip Code)
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8		Melissa Brassell, MD	Assistant N	ledical Exam		i i i Pe	nn Street, Ba	namore,	MID 2120	וע			
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DHMH 17 Rev 1/2001

		1	For State Registrar	State of Marylan	-	artment of H		lental Hygien	2000	41449
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	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or TOWSON	Location of Death	L	c. County of Death BALTIMORI	Ξ
	Funeral Director		5. Social Security Number 6. S 219-54-2837 Usual Residence of Decedent	ex 7. Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea May 25,195	9. Birthy Coul	place (State or Foreign htry) MD
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36	be filed within 72 hours after death with the Maryland tall tyglene. Id other then "natural", or iteme 23a or 28e-f ehow other then "natural", or iteme 23a or 28e-f ehow event. The Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 5 Yes 2 □ No If Yes, Give Year or Dates: 1971-		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	within 72 hou ene. then "nature he Medical E	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation	16a. Dece (Give life.	dent's Usual Occup kind of work done of DO NOT use retired ection Ag	during most of work ()	ing	Kind of Business/In	dustry Collection
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Maryland	s 1 and 2 should if Heelth and Men item 27 is marks other traumatic	ဥ	19a. Informant's Name/Relationship (Joan Bedford - W				and Number or Run	al Route Number, City Dl, Reist		
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Balti	permit. Pag Depertment importent: if eny injury o		21. Signature of Funeral Service Lice				ss of Facility ELT	NE FUNERAL Road, Reis	HOME	, MD 21136
68760,	Physician /Medical Examiner pe prize pe	Ical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conseq b. Due to (or as a conseq c. Separation of the conseq Due to (or as a conseq Due to (or as a conseq d.	uence of): uence of):		g, such as cardiac MCA (SCHC)	1 >		Approximate Interval Between Onset and Death
P.O. Box 68	ne death certifics the attending pt thed for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	Ectopic pregnancy Other (specify)	,		23d. Date of deliv Month	ery Day Year
	quires thet the sound on signed by all the detact	۵	Part II. Dther significant conditions	contributing to death but not res	culting in the c	underlying cause giv	en in Part I.	23e. Did tobacce	use contribute to t	/
Il Records,	. The law requirate has been page 2 should	Completed	Metasta	sic Blado	dev	cane	17	24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
of Vital	ysicien:] nis certificat i director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 1 Inpatient 2	ER/Outpatie	nt 3□ DOA Oth	00	th (Check only one) ome 5 - Residence	6 ☐Other (Speci	fy)
Division o	ttending death. ctor: After y the fune	Certification:	27. Manner of Death 1	De Blace of Injury - At h	28b. Time of Injury ome, farm, st	M 1	y at k? Yes 2 □ No	28d. Describe how in 28f. Location (Street City or Town, Str	and Number or Rur	al Route Number,
	To the Hospital or A within 24 hours effer To the Funeral Direct Completely filled in b	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, dea ation and/or in	th occurred at the time timestigation, in my o	me, date and place, ppinion, death occur	and due to the cause rred at the time, date a	(s) and manner as and due to	stated. o the cause(s)
•	To the To the comp	Ň	29b. Signature and title of certifier CHMMA	Sociaur	()	29c. Licens	of 21 34.		Date signed (Month)	
	3+1		0 1111111	ano MD 67	7011	V. Char	1css+1	Balhuro	re MD	2/20/
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 2 8	32. Registrar's Signa	ature A	porte				

			1 = State Amend Items	State of Maryland / Do 4c,24a,26 per dr	epartment of He Serificate 672	ealth and Men 06dhb	tal Hygiene	006 41450
	Physici		1. Decedent's Name (First, Middle, Last,	ETTA CRE	25 bV	1	Date of Death Month Da December	y Year 7.30A M
	/Medic Examir		4a. Facility Name (If not institution, give		/4b. City, Town, or I	Location of Death	40	County of Death
	Funeral Director		5. Social Security Number 6. Sec 2 18 - 50 - 1584	x 7. Age (In yrs. last birth	nday) If Under 1 Year Months Days	Hours Min. . (Date of Birth Month, Day, Year)	9. Birthplace (State or Foreign Country)
	nyland show	.	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town				10d. Inside City Limits
	th the Ma or 28e-f s	Director	10e. Street and Number	A BA17	10f. Zip Code		10g. Cit	1 ☐Yes 2 No
	ns 23e c	Funeral D	2736 Ab/hA1	n Are 12. Was Decedent Ever in U.S.	13. Was Decedent of His	2/3 panic Origin? (Specify	Yes or No-	U.S.A 14. Race - American Indian,
920	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It and Mental Hyglene. It is marked other then "natural", or items 23e or 28e-f show treumatic event, the Medical Evertifier must be rectified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify Cuban 1 ☐ Yes 2 No	, Mexican, Puerto Rica Specify:	n, etc.)	Black, White, etc. Specify: B/ACX
215-0036	within 72 ho ene. then "natur he Medical.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	le completed) (Decedent's Usuaf Occupat (Give kind of work done du life. DO NOT use retired)	tion uring most of working		ind of Business/Industry
2	filed with Hygiene. Ither ther		12 A RA d 2 17. Father's Name (First, Middle, Last)	2 yrs,	TIEKK	18. Mother's Name (Fir		Timis EXAMLE
Maryland	ould be Mental Marked o	To Be	Hugh Ch	nisholm		RAThel	mc C/	lennon
Mar	and 2 sho ealth and n 27 ie m		19a. Informa 's Name/Relationship (Ty	A/Mel 196. N	Mailing Address (Street ar	nd Number or Rural Ro	1.	er Town, State, Zip Code)
nore,			20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State cemetery,	Disposition (Name of , crematory or other place		20c. Lo	ocation - City or Town, State
Baltimore	permit. Pages Department of the Importent: If ite any injury or of once.		'4 □ Donation 5 □ Other (Specify) 21. Signature of Fureral Service Licens	_	22. Name and Address	of Facility	some	butas md
	₹ C = 6 O		23a. Part 1. Enter the disease, or compl	ications that caused the death. Do no	ot enter the mode of dying	such as cardiac or res		Approximate
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. Metasta	tic Pe	nereal	ic C	Interval Between Onset and Death
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8760,	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequence of	f):			1
Θ		/Medi	IF FEMALE:	23c. If yes, outcome of pregnancy				004 Day - 644 B
.O. Box	that the death certifit ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delivery Month Day Year
<u>a</u>	eg ud	by	Part II. Other significant conditions cor	ntributing to death but not resulting in t	n in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nothrow		
Records,	e law has b je 2 sl	Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vita	icien: certific rector,	o Be C	25. Was case referred to medical examiner?	Hospital:	Other	26. Place of Death (Ch	/	Daughter's
Division of Vital	ding h. After fune	\vdash	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tir Injury	me of 28c. Injury a	4 Nursing nome	5 Hesidence Describe how injur	
Divisi	after death. Director: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		ocation (Street an City or Town, State	d Number or Rural Route Number,)
	To the Hospitel or Atten- ithin 24 hours after deat To the Funerel Director: completely filled in by the	ledical C	29a. Certifier 1 Certifying Physical Check only cone) 2 Medical Examination	sician: To the best of my knowledge, ner: On the basis of examination and/and manner stated.	death occurred at the time for investigation, in my opi	, date and place, and d nion, death occurred at	lue to the cause(s) the time, date and	and manner as stated. I place, and due to the cause(s)
	To the ithin To the compl	Me	29b. Signature and title of certifier	elulas	29c. License	number 024303	29d. Dat	te signed (Month, Day, Year)
1	8)		30. Name and address of person who co	impleted cause of death (Item 23a) (T	ype, Print) Ball	LO , MID) 21	224
Ų,	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 8 2006	32. Registrar's Signature	rille)		<u> </u>	I

DHMH 17 Rev 1/2001

John Frederick Car	1- For State	State of Man	•	it of Health and Mental e of Death		2006 4145
Physician/ Medical Examiner		e (First, Middle,Last)			2. Date of Death Month Da December 19	3. Time of Death
Wedical Examine		f not institution, give street and	ohn Frederick number)	Carroll, Jr 4b. City, Town, or Location of De		4c. County of Death
	Rt. 290 and		7. Age (In yrs. last birthda	Chestertown If Under 1 Year If Under 24	Hrs. 18 Date of Birth/M	Queen Anne's M/DD/YYYY) 9. Birthplace (State or
Funeral Director	218-48-70				9-13-194	Foreign
any	Usual Residence of 10a State	Decedent 10b, County	10c. City, Town or I	ocation		10d. Inside City Limits
* .	Md	N/A	Baltimor			1 Yes 2 No
tith the Maryland 23a or 28a-f show notified at once.	10e. Street and Nur 703	mber Edgewood Stre	et	10f. Zip Code 21229	_	Citizen of What Country?
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Marrie	ed 2 X Married Armed	Forces?	B. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc.
s after de rraf", or niner mu by Fu	3 Widowed	4 Divorced If Yes, Give or Dates:	Year	1 Yes 2 No specify:		Specify: Black
2 hours "natur LExam	15. Decedent's Ed Elementary/Seco	ducation (Specify only highest goodary (0-12) College		edent's Usual Occupation (Give kinding most of working life, DO NOT use		o. Kind of Business/Industry
215-0036 be filed within 72 hournel Hygene. ked other than "nattent, the Medical Exament, the Medical Exames Be Completed	12th gr	ade 2	years 1)river		American Red Cross
215-1 be filed ntal Hyg rked oth ent, the	17. Father's Name (Solomon			Sede1	ame (First, Middle, Maid 1a Wiggin	•
MD 21 rd 2 should be the and Mer m 27 is mar aumatic eve	1	me/Relationship (Type, Print) Carroll - Wife	- 1	lailing Address (Street and Number	or Rural Route Number,	
re, M 1 and 2 f Health If item 2 er traur	20a. Method of Disp		20b. Place of D	B Edgewood Street isposition (Name of cemetery, or other place)	Date 20	c. Location - City or Town, State
Baltimore, permit Pages I ar Pepartment of Hee mportant: If ite njury or other tr	4 Denation 5	Other Specify:	Garriso	on Forest Vet 1 22. Name and Address of Facility		Owings Mills, Md
	XVM	red UNG	unut	4300 Waba	March F/H sh Avenue	Baltimore, Ms 21215
Physician /Medical	failure. List onl	ly one cause on each line.	it callised the death. Do not el Gunshot Wound of He	nter the mode of dying, such as cardia	ac or respiratory arrest, s	Shock, or heart Approximate Interval Between Onset and Death
xaminer	Immediate Cause (F or condition resultin		s a consequence of):	<u> </u>		
ner	Sequentially list cor if any, leading to im	mediate Due to (or a	s a consequence of):			
ited I ansit Examiner	(Disease or injury the events resulting in o	nat initiated C.	s a consequence of):			
to be executed sisting and burial - transit	UNPENDED	d. AMENDE	D			
	IF FEMALE: 23b. Was decedent p	pregnant in the	s, outcome of pregnancy	Fetal death 3 Ectopic pre		23d. Date of delivery Month Day Year
V _ 0 = 1 U	past 12 months	lo 9 Hoknown 4 Pre	egnant at time of death 5	Other (Specify)		,
. 4 . 4 .				the underlying cause given in Part I.		to use contribute to the cause of death?
ds, P equires t een sign ould be o					1Yes 2 24a. Was an	No 3 Probably 4 Unknown 1 24b. Were autopsy findings available
Division of Vital Records, P.O. I tal or Attending Physician: The law requires that the ris after death. at Director: After this certificate has been signed by the funeral director, page 2 should be detacherentification: To Be Completed by PP entification: To Be Completed by PP		···	.		_ autopsy performed 1 ✓ Yes 2	prior to completion of cause of death? No 1 Ves 2 No
ital Rician: T	25. Was case referrence examiner?	red to medical]	26 Place of Death (Che		
of VI ng Phys After this meral di n: To	27. Manner of Death	2 No 28a Da	Inpatient 2 ER/Outpate of Injury onth. Day, Year)	e of Injury 28c. Injury at Work?	28d. Describe how i	
Sion Attendi r death. ector: /	1 Natural 2 Accident	Investigation	9, 2006 0000 hr	S 1 Yes 2 ✓ No street, factory, office building, etc.	Subject shot se	t and Number or Rural Route Number, City
Division o spital or Attending hours after death. neral Director: Aft filled in by the func Certification:	3 Suicide 4 Homicide	o Could not be	fy) side of road	stroot, ractory, office building, etc.	or Town, State) Rt. 290 and 1705,	
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificantle on piletely filled in by the funeral director. Medical Certification: To Be C	10.110011 0111)	Medical Examiner: On the bas	is of examination and/or inve	occurred at the time, date and place, a stigation, in my opinion, death occurre	1 1	
A To S To S S	29b. Signature and	and manner title of certifier		29c License number	1	d. Date signed (Month, Day, Year)
	30, Name and addre	ess of person who completed co	···	O.C.M.E.	De	ecember 20, 2006
2	Ling Li, MD	Assistant Medical Ex	aminer 111 Penn S	treet, Baltimore, MD 21201		
State Registrar		n, Day, Year) 32.	Registrar's Signature	<i>f</i>		
Drivin iz Kev i/2001		A.	ORIG	MAL .		

/Medical Examiner attending physician and for use as the burial-trar signed by the a d be detached for P.O. or Vital Records, spital or Attending Physician: 1 hours after death. uneral Director: After this certificat y filled in by the funeral director, p. Division To the Hospital o within 24 hours aff To the Funeral Di completely filled in

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

"natural", or items 23a or 28a-f show dion! Examiner must be notified at

Medical

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other than

2 should be finance and Mental F 27 is marked or traumatic ever

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Health tem 27 i

and manner stated. 29b. Signature aportitle of certifie

PHYSICIAN

D0063973

29c License number

29d. Date signed (Month, Day, Year) 2006

5th FLOOR BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAROCHIA AMISHA 31. Date filed (Month, Day, Year)

1830 E MONUMENT

32. Registrar's Signature

State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Edith J. Catterton Month Day Pay Year 2006 01.15AN **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KALTIMORZINACHTON MESTICHE ANUME VEN 151 CHNTES NEMIE teur De If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 316-28-0808 1 □ M 2 🖸 F Hours Director 1931 July. Michigan Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, <u>the Medical Examiner must be notified</u> at Baltimore Anne Arundel Maryland Director 1 □Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 612 Biscay Avenue USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any Injury or other traumatic event the incit Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify ģ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Venetian Blind Co. Factory Worker Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Craft Arthur Pearl Rantz ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Passadena Md. 21122 19a. Informant's Name/Relationship (Type, Print) Thelma E. Chadwell (Sister-in-law) 357 San Gria Ct., Pasadena, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/23/06 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility McCully-Polyniak Funeral Home, P 3204 Mountain Rd., Pasadena, Md. 21122 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Paset and Death Immediate Cause (Final Olzhemers **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Anknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1/Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier and manner stated. 29b. Signature and Mur of certifier 29d. Date signed (Month, Day, Year) ME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Bussie totopina JASMED AL 501 31. Date filed (Month, Day, Year 32. Registrar's Signature State DEC 2

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 5 . . AM 4a. Facility Name (If not institution, give street and number) /Medical .6 4b. City, Town, or Location of Death Examiner 4c. County of Death Ballnon Samanden 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Hours 1 M 2 F 227-40-5913 Director 5,1930 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified Director Md 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? or a filed within 72 hours after death with ms 23a c 4320 2121 by Funeral USA . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ו "natural", or item: fedical Examiner ה Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21/15-0036 Specify: Black 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Completed ortant: If Item 27 is marked other than "naturinjury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Aid Baltimore eachers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 2 GT ook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Department of Health ar Important: If Item 27 is any injury or other trau Saratoga Nicholas 200K 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 30/06 21. Signature of Funeral Service Lice's 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bacterial Penvini Sequentially list conditions, if any, leading to immediate cause. Either Univerlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed Due to (or as a consequence of) signed by the attending physician a d be detached for use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, cate has been signated by 4 Junknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy pertorme death? 1 ☐ Yes 1 2 No 2□ No Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes . 2**▼** No P 1 🔽 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending (Month, Day Year) 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KAICAV. 12/26/.6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17 4 Aleri. Good samening Scloub MP

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Parieut Iconus ors Coudler, John B Baltimore, Maryland 21215-0036

Physic /Medi Exami

Funeral Director

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Please Type or Pr				-	_					
1- For State of N	laryland / Depar Cert	tment of Heal <i>ificate of Dea</i>		ental Hygie Reg.	0000	1.11.51				
1. Decedent's Name (First, Middle, Last)			2. Date of Death	ate of Death 3. Time of Death						
JOHN & CANDLER			7	Day Year 9 M						
4a. Facility Name (If not institution, give street and number	r) .	4b. City, Town, or Loca		244	4c. County of Dear	h				
Simi Hospital of Balli	ncie.		iki		N/A					
5. Social Security Number 6. Sex 7. /	Age (În yrs. last birthday)	If Under 1 Year If U	urs Min.	8. Date of Birth (Month, Day, Ye	ar) Co	hplace (State or Foreign				
210-28-1325	83 Yrs.			Sept. 3,	1923 Ma	ryľand				
Usual Residence of Decedent 10a. State 10b. County		10d. Inside City Limits								
Maryland N/A	Baltimore				1 X Yes 2 □ No					
10e. Street and Number	Datemore	10f. Zip Code		10g.	Og. Citizen of What Country?					
202 Hawthorn Road		21210	1		U.S.A.					
11. Marital Status 12. Was Deceder Armed Forces	t Ever in U.S. 13. Wa	as Decedent of Hispan Yes, specify Cuban, Me		ity Yes or No-	14. Race - Ame					
1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give]No	Tes, specify Cuban, we ∃Yes 2 X No <i>Sp</i> e		ican, etc.)	Black, White	e, etc.				
Maryland N/A 10e. Street and Number 202 Hawthorn Road 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40 5+ year	WWII	·	cony.		Specify: Wh	ite				
15. Decedent's Education (Specify only highest grade completed)	ı (Give kir	nt's Usual Occupation nd of work done during	most of working	g 16b	. Kind of Business/	Industry				
Elementary/Secondary (0-12) College (1-40	r 5+)	o <i>not use retired)</i> age Banker			Dominio o					
17. Father's Name (<i>First, Middle, Last</i>)	rortg		Mother's Name ((First, Middle, Maid	Banking					
			1ma		,					
Walter BeVille Candler 19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street and N		Adams		Zin Code)				
Ann B. Candler (wife)										
20a. Method of Disposition	20b. Place of Disposit	ion (Name of	Darth		aryland 21210 20c. Location - City or Town, State					
1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Ç (cemetery, crematory or other place)								
21. Signature of Funeral Service Licensee	LOUGOII Par	Name and Address of F	Facility	7-00 ра	<u>ltimore,</u>	Maryrand				
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212										
23a. Part1. Enter the Tsease, b complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lis only one cause on each line. Approximate interval Between										
Immediate Cause (Final										
disease or condition resulting in death) a. Due to (or as a consequence of):										
	V									
	era consequence org									
that initiated events										
	s a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II Other significant conditions contributing to death										
IF FEMALE:				_						
23b. Was decedent pregnant in the past 12 months?	2 ☐ Fetal death 3 ☐ E	ctopic pregnancy		23d. Date of delivery Month Day Year						
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			World Day					
Part II. Other significant conditions contributing to death	but not resulting in the under	erlying cause given in F	23e. Did tobaco	obacco use contribute to the cause of death?						
ty Porlipidence prostate Carcinoma Controvosculo accio		obably 4 □Unknown								
Prostale Carcinoma				24a. Was an autopsy performed	prior to d	topsy findings available completion of cause of				
Centrovosculy accor	Leut.			1□ Yes 2 🗹		2 No				
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Uroa	Nant OFFROntestiant	Other:		(Check only one)						
27. Manner of Death 28a. Date of Ir	tient 2 ER/Outpatient jury 28b. Time of	JUDON 4		e 5 ☐ Residence 3d. Describe how in	6 Other (Spec	cify)				
1 Matural 5 Pending (Month, E	lay Year) Injury	28c. Injury at Work? M 1 ☐ Yes			ijary oodaned					
3 Suicide 6 Could not be 28e. Place of i	l njury - At home, farm, stree			f. Location (Street	and Number or Ru	ral Route Number.				
4 ☐ Homicide determined building,	ate)	,								
(Check only 2 Medical Examiner: On the basis	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and du									
27. Manner of Death Matural 2	nateu.	29c. Liçense num	ber	29d	Date signed (Monti	n, Dav, Year)				
		0			3	,,				
30. Name and address of person who completed cause of	death (Item 22a) (Type Bri		000		cenbe, 8	4, 2006				
C		2	12:1-1	6)	Baltino					
31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	anai Ito	operal	0	15aun 10	7-6:				
DEC 2 8 2006	was St. A.	act.								
23m V 23 V 22 V 1		-								

5

St Regist 06-09678 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dorothy Cornish State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Cornish 0908 hrs Medical Examiner Dorothy December 19, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** NA 1027 Cathedral Street If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) g. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Days Hours Director 4-26-1932 212-34-6181 Country) 2X F M 74 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 , or items 23a or 28a-f show Baltimore NA notified at once. hours after death with the Maryland rector 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 1027 N. Cathedral St Apt. 5-C 21201 USA Ö Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married Yes Black 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify 3 X Widowed marked other than "natural", c event, the Medical Examiner þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) i. Pages I and 2 should be filed within 72 I treent of Health and Mental Hygiene.
rtant: If them 27 is marked other than "rior other traumatic event, the Medical E. College (1-4 or 5+) Baltimore, MD 21215-0036 Homemaker 10th grade Own Home 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stone Johnson Luereanna Be Robert. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucinda Cornish Daughter 241 N. Monastery Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State 12-29-06 Greenmount Cem. Baltimore, Md Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Warne 1101 E. North Ave., Baltimore, Md 21202 Ou 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and sician/Medical UNPENDED AMENDED attending physician or use as the burial -Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 뮵 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. <u>۾</u> Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, certificate has been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other; examiner? Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 After this 1 V Yes ဥ 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 V Natural Yes 2 No Pending within 24 hours after death.

To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number December 21, 2006 O.C.M.E. e and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ORIGINAL DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Cashell Day 25 1515 December 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Augsburg Lutheran Home Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🕅 F Director 95 1911 Maryland 218-64-6082 January Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumast event, the Medical Examiner must be notified at Maryland | Baltimore Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 6811 Campfield Road United States of death \ Funeral America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) $12 \, \text{th}$. College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill trient of Heal h and Mental H tant: If item 27 is marked other. Be Mark Lee Robey Esther V. Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 123 Lassiter Circle, Finksburg, MD 21048 Marlene A. Cashell 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Bandl 2 Cremation 3 Removal from State Druid Ridge Cemetery December 28,2006 Pikesville, Maryland permit. Pages
Department of
Important: If it
any injury or or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility | Oring Byers Funeral Directors 21. Signature of Funeral Service Licensee 8728 Liberty Rd Randallstown, MD 21133-4784 Cellur 160333 23a. P. d. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athorosclevotic Ceveloval Vascula Physician eavs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed attending physician and for use as the burial-transil Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has h lirector, page 2 s autopsy performe 1 Yes 2 Mo director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: AND Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this ours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 A Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 6 To the Hospital within 24 hours a To the Funeral C Hospitai 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D37 573 December 26,2006 cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

25

MD

ZIbell

Reisteurtown

MD

21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 23 2006 **Physician** 10 20 PM December CAROL J. CRAWFORD /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Medical Burnie Slen Anne southmore 8. Date of Birth (Month, Day, Year) JAN • 12 • 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Davs Hours 1 □ M 2 K F Director 337-26-6802 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director ANNE ARUNDEL SEVERN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 1908 ARMOR CT USA 21144 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 0 1 ☐ Yes XXNo þ 3 Widowed 4 □ Divorced WHITE "natural" Year or Dates: Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any Injury or other traumatic event, the Mediral 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MATTHEW BUTKOVICH FRANCES MCGEE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MS. KAYE E. CRAWFORD 1908 ARMOR CT.; SEVERN, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JANUARY 8. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NAT'L. CEM. 2007 ARLINGTON, VA 21. Signature Service Licensee 22. Name and Address of Facility 1 SECOND AVE. SW M01411 SINGLETON FUNERAL HOME; GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer **Physician** METERSTERE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burlal-trans Due to (or as a consequence of): P.O. Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. DEXMISSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Nrg MIC 24a. Was an autopsy performed? 2156426 1 TYes 1∐ Yes 2 XNo al or Attending Physician: after death. I Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA P 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Matural 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo 051500 12124,200

State Registrar

31. Date filed (Month, Day, Year) 2006

MAJERODYNM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ULEN

HOWITAL DRIVE

2100

BMEMIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mary Elizabeth Condon State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle.Last) Physician/ Date of Death Mary Elizabeth Condon Month Day December 22, 2006 Medical Examiner 2355 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Sinai Hospital **Baltimore** N/A 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or **Funeral** Director Months Days Hours 215-72-8135 April 17,1959 1 M 2 XF 47 Country)Ohio Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 No Maryland N/A Baltimore Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 **USA** 2700 Chelsea Terrace Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes Widowed 4 Divorced If Yes, Give Year Specify: White 1 Yes 2 X No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than " Waitress 12 Restaurant 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) James Condon traumatic event, Be Alice Keister 19a. Informant's Name/Relationship (Type, Print) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Shepard, Sister 4910 A Meridian Way #2 Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 12/26/06 Baltimore, Maryland Donation 5 Other Specify 10 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Cremation Society Of Maryland, Inc. Thomas Gregor (Frederick Road Baltimore, Maryland 21228 23a. Part I. Enter the disease, or compli ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearl Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a Complications of chronic ethanolism Death Immediate Cause (Final disease **Examine** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical physician a UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the use as t Live birth 3 Ectopic pregnancy Dav Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed has been 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? раце certificate ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? DOA this Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes 2 No ۵ After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 V Natural Yes 2 No death To the Funeral Director: 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 ____ 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 23, 2006 Legas 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner 31. Date filed (Month (Sex Year) 32. Registrar's Signature State 2008

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			1 - State of Maryland State of Maryland		artment of H			ene g. No. 00	6 4	1460	
П	Dhysisi	20	Decedent's Name (First, Middle, Last)				2. Date of Death Month	1	3. Ti	ime of Death	
	Physici /Medio		BEATRICE	COLE				r 26 20		755 A ^M	
Ž.	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of D	Death	4c. County of			
	Euparal		GREATER BALTIMORE MEDICAL CEN 5. Social Security Number 6. Sex 7. Age (In yrs. Ii		TOWSON If Under 1 Year	If Under 24	Hrs. 8. Date of Birth	BALTI	MORE 9. Birthplace (S	State or Foreign	
	Funeral Director		224-24-2346 1 M 2 T F 82	Yrs.	Months Days	Hours	09/26/1	924	Country)	VA	
	pr >		Usual Residence of Decedent 10a. State 10b. County 10c. City	. Town or Lo							
	daryla ed e	20	MD BALTIMORE		CATION DALLSTOWN	r				ide City Limits Yes 2 1 No	
	the A	Director	10e. Street and Number	MANL	10f. Zip Code		10	g. Citizen of Wh		- X	
	3a or	D	3911 BRYONY ROAD			21133		g. Olizon of Wil	US	Δ	
	deatl	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of H		? (Specify Yes or No- Puerto Rican, etc.)		American Indi		
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. If of Health and Mental Hygiene. or other traumatic event, the Madical Examiner must be notified at or other traumatic event.	by	1 ☐ Never Married 2 M Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:	ruento raican, etc.)	Specify:	White, etc.	ITE	
2-0	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	leni's Usual Occup	pation	f working 1	6b. Kind of Busi	ness/Industry		
121	within ne.	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired	d) -		DETAIL			
р Б	filed v Hygie rther t		17. Father's Name (First, Middle, Last)	CUSTO	MER SERV		Name (First, Middle, M.	RETAIL			
	should be tind Mental Is marked or umatic eve	To Be	ROBERT	KING		GERTI	RUDE		SM	ITH	
	1 and 2 shd Health and sm 27 is m ther traum		19a. Informani's Name/Relationship (Type, Print) LEON COLE / HUSBAND				RANDALLSTOW	-			
a a	Pages 1 and nent of Health int: If Itam 27 iry or other tr		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	metery, cren	sition (Name of natory or other place			Oc. Location - Ci	ity or Town, Sta	ate	
Ħ.	t. Pag rtment ntant: I		4 □Donation 5 □Other (Specify) OHE				2/27/2006		RSTOWN,		
Ba	permit. Pag Department Important: It any injury o		21. Signature of Funeral Service Licensee		Name and Addre		SOL LEVINSON ROAD - P		-	C. 21208	
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.						Appro		
1	Physician		Immediate Cause (Final disease or condition COM GEST	Sur	Hear	t Fa	NIMA		Onset	and Death	
	/Medical Examiner		resulting in death) Due to (or as a consequ	ence of):	7. (7.)	A-	and a si				
	*	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)	ence of):	anou	C /	chaosi s				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	100	SIAFA	cies	1/10				
o,	an an irial-tra		resulting in death) Last Due to (or as a consequ	ence of):	00011	0,0,					
8760	icate be executed physician and sthe burial-transit	dlcal	d								
9 ×	eath certific attending p	•	IF FEMALE: 23c If yes, outcome of program								
Вох	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month		Year	
o.	that the de led by the a detached t	hysi	1 U Yes 2 ☑No 4 ☐ Figurant at time of de 9 ☐ Unknown 9 ☐ Unknown	u 5_	Other (apacity)						
o, D	signed to det	by P	Part II. Other significant conditions contributing to death but not result	Iting in the un	derlying cause give	en in Part I.	23e. Did toba	cco use contribu	ute to the cause	e of death?	
rd	w require been sig should t	ted .	coronary artery di	sea	Se		1 ☐ Yes	2√2 No 3	Probably	4 □Unknown	
ecc	has be	Completed	diabetes welling				24a. Was an autopsy	24b. We	24b. Were autopsy findings available prior to completion of cause of		
		Cou	perpheral vasula	10	liseas	10	performe	ed? dea	th? Yes 2 1 No	/	
Vita V	certifi	Be	25. Was case referred to medical examiner?		Oth		Death (Check only one)				
0	Phys rthis ral di	2	1 res 2 2 2 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	R/Outpatient 28b. Time of		4 🗀 Nuisii	ng Home 5 Residen 28d. Describe how				
0	5 # E	tlor	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year)	Injury	28c. Injun World	k?` Yes 2 ∐ No	200. 2000130 1101	injury occurred			
Division of Vital Records,	or Atter ifter dea Director in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number State)	or Rural Route	Number,	
_	To the hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinating	vledge, death	occurred at the lin	ne, date and p	lace, and due to the cau	se(s) and mann	er as stated.		
	the H hin 24 the F nplete	Medical	and manner stated.	on and or my							
	50 7 × 10	~	29b. Signature and title of certifier CHUHUK SMAWW M)		29c. License			1. Date signed (/ 12/26		ar)	
	2/		30. Name and address of person who completed cause of death (Item	23a) /Tunn 1							
	Y		CYNTHIA SOCIANO MO 670		Marie	154,1	Bachma	16 M	0 212	04	
	Sta Registra		31. Date filed (Month, Day, Year) DEC 2 8 2006 32. Registrar's Signate	ire Apa	Sec. 3						

Cole, Beatrice

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU b Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Maude Collier Dwyer 7:30 Ам December 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Presbyterian Home of MD Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign Country) 2 MISSISSIPPI Months 1 M 2 F November 20,1912 94 410-07-7528 Yrs Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Towson 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Georgia Ct. 21204 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 legal secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Howard Collier Helen Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Dwyer/daughter 107 Bellemore Rd. Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount crematory Dec. 23,2006 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licensee Bay land 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of)

Physician /Medical

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth ery liqury or other treumstic event QRCS.

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Intel Hygiene.
Ind other than "natural, or items 23a or 28a-f show covent, the Mudical Examinar must be notified at

Maryland 21215-0036

Baltimore.

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Records,

Division of Vital

Examiner

Examine ettending physicien and for use as the burial-transit Completed by Physician/Medical signed by the ef peeu has certificate 2 this After this funeral of Certification: To the Hospital or Attandin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

Immediate Cause (Final disease or condition resulting in death) frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant

2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending investigation 2 Accident М 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

Medical

31. Date filed (Month, Day, Year)

037016

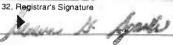
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. (Garles St. Scate 4105 Dolther, mg 2/204 Kenneth M. Greeke, mo

mo

State Registrar

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/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. To the Hospitel within 24 hours a To the Funeral C

Physician

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Examiner

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rthen "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be file Department of Health and Mental by Importent: If Item 27 is marked oth any july or other traumatic event ang. injury or other traumatic event

Physician

detached for

: After this certifica stuneral director, p

s after de-rai Director: Alte

filled in by

filed within 72 hours after

Baltimore, Maryland 21215-0036

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes > No ို Certification: 27. Manner of Death Natural 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12.26.06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

State Registrar

Eddie Nakhuda, M.D. 31. Date filed (Month, Day, Year)
DEC 2 8 2006

2300 Dulaney Valley Rd.

32. Registrar's Signeture

Timonium, MD

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2006 Angela T. DeBole /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Good Samaritan Hospital If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign November 30 1918 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2¥3¥F Yrs. 217-07-9040 88 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location ir than "natural", or itama 23a or 28a-f show the Medical Examiner must be rediffed at 1 Yes 2 □ No Completed by Funeral Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 U.S.A. 4014 Parkwood Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZANo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Clothing 12th grade permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If itam 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Puglisi Angelo DeBole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 217 Felton Road, Lutherville, MD 21093 Paula Burkholder Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State Dec 29 2006 Baltimore, Maryland Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21206 6415 Belair Road, Baltimore, Maryland 23a. Part1. Enter the disease shock, or heart lailure for limmediate Cause (Figure disease or condition resulting in death) implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Athensclerstic Physician acces 5 /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' 2 No certificate 1 Yes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After this 28b. Time of Injury 28a. Date ol Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Š 4 Homicide peliii 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier Lock Raiver howlevered But towns, Manylwed 30. Name and address of person wife completed cause of death (Item 23a) (Type, Print) Scanges 5401 du) 32 Aegistrar's Signature 31. Date liled (M State Registrar

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burnal-transit

Physician

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Examiner

Funeral Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified or once.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Examiner

	d								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	230	: If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl death 3 ☐ Ectopi				23d. Date Monti	,	Year
Part II. Other significant condition	ons contri	ibuting to death but not res	ulting in the underlyin	g cause	given in Part I.		cco use contrib		
						24a. Was an autopsy performe 1 Yes 2 €	ed2 prid	ere autopsy find or to completion ath? Yes 2 \(\) No	n of cause of
25. Was case referred to medica examiner?					26. Place of De	eath (Check only one)			
1 ☐ Yes 2 ☑ No	Hos	spital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA	Other: 4 Nursing	Home 5 Residen	ce 6 Other	(Specify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investi	gation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M		Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	1	
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fac y)	tory, off	ice	28f. Location (Stre City or Town,	et and Number State)	or Rural Route	Number,
29a. Certifier 1 Y Certifyir (Check only one) 2 Medical	ng Physic Examine	cian: To the best of my knor: On the basis of examina and manner stated.	wledge, death occurr tion and/or investigate	red at th	e time, date and plac ny opinion, death occ	ce, and due to the cau curred at the time, dat	se(s) and manr e and place, an	ner as stated. d due to the ca	use(s)
29h Signaturetan title of bertifie				20c Lic	ense number	004	Date signed (Manth Day Vo	

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Registrar DHMH 17 Rev 1/2001

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State

MD

Glen Burnie

22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Drive

Hospital

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 4-28AM **Physician** Margaret Harris Dingman Dec 2006 3 Z /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/AJohns Hopkins Bayview Medical Ctr. Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Feb. 7,1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☑ F Pennsylvania 83 186-14-4954 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or Items 23a or 28a-f show other treumstic event, the Medical Examinar must be notified at Dundalk 1 ☐ Yes 2 No Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with tent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23a or 2 ury or other treumatic event, the Medical Examinating must be not United States 21222 7402 Waymuth Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify: Specify: 3 White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Black John Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21161 Mrs. Rita M. Donoho (Daughter) 2412 McComas Road White Hall, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) ¥IXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any Injury or once. Baltimore, Maryland 12/28/2006 (Specify) Other (Specify) Oak Lawn Cemetery 4 Denation 21. Signature of uneral Service Library 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Physician 6-1 /Medical Due to (or as a consequence of) **Examiner** reunshia S. uential / list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 60-90 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 2265. Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 5-37 page 2 s certificate 1 Yes 2 XNo 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie cal

Dingman, Margaret To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 23, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Esstern BOH, My 21224 32. Registrar's Signature

State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 22 2006 Physician 9:26 A M BERNARD Ε. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a **Baltimore** 1400 Belt Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth April Day, Year) April 10,1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 MM 2□ F Mary Land 212-28-0795 77 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at N/A Maryland Baltimore 1 RYes 2 □ No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1400 Belt Street 21230 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Stationary Engineer W.R. Grace & Co. permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked othn any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bernard Ebkens Maria Behrens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine M. Ebkens 1400 Belt Street, Baltimore, Maryland (Wife) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition New Cathedral Cem. 1 Burial 2 Cremation 3 Removal from State 12-28-06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funéral Service Liensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
130 E. Fort Avenue, Baltimore, Maryland 21230 MAN olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a Part 1. Enter the disease, or composhock, or heart failure. List only of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONI **Physician** WEEK /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed led by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sete has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificete 2. No 1 Yes 2 1 No 1 Yes within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) w 1 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 2 8 2006 Registrar

AMEND TIEW#1 perPHYS C862 12/28/06 WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Priscilla

Dorie Edwards L. Edwards Month Physician December 19, 2006 9:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Madonna Heritage Jarrettsville Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/24/1924 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Min. 81 Days Hours 1 □ M 2 💢 F 214-26-6008 Yrs MA Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2 No Director Harford Jarrettsville 10e Street and Number 10f Zip Code 10g. Citizen of What Country? ö death with 3982 Norrisville Road 21084 USA or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married ☐ Yes 2 Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify SpecifyWhite þ 3 Widowed 4 Divorced Year or Dates: natural Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Education is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 le marked other then " Elementary/Secondary (0-12) College (1-4or 5+) School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Littmann, Sr. Charlotte Brattig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla R. Edwards/Daughter 2806 Harford Road Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec 21 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
ony Injury or ot 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCUD Physician disease or condition resulting in death) y cams /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ANo 9 ☐ Unknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ been sig should b demen to 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 Yes 2 No 1 Yes I or Attending Physician: after death. Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) \$253,3 kell 113,0 1 ☐ Yes 2 1 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu investigation М 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 31295 Wend Xlotz 12/19/66 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 Charles Site 4202 mil 6701 Towson 31. Date filed (Month) 32. Registrar's Signature State Solver Registrar

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Division or Vital Records, P.O. Box 68760,

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.O. Box 68	that the death certifical ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal	death 3□	Ectopic pro					230	I. Date of d Month	elivery Day Year
<u>α</u>	The law requires that the tee has been signed by the bage 2 should be detached.	þ	Part II. Other significant conditions con	etributing to death but n	ot resul	lting in the u	nderlying c	ause give	n in Part I.		23e. Did to	`	- 4	to the cause of death? Probably 4 □Unknown
tal Rec		e Completed	25. Was case referred to medical						OC Place	of Dooth	24a. Was a autop: perfor 1 Yes	med? 2 No	24b. Were a prior to death?	
Division of Vital Records,	ding Phys h. After this funeral dir	ToB	evaminer?	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Y		ER/Outpatien 28b. Time of Injury		8c. Injury Work	r: 4 Nur	rsing Hom	e 5 Resid	ence 6		ecify)
Divis	in the second	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At hor Specify,	me, farm, str	eel, factory	r, office		28	Bf. Location (S City or Tow		lumber or i	Rural Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	ledical	(Check only 2 Medical Examir one)	sician: To the best of n ner: On the basis of ex and manner stated	aminati	vledge, death ion and/or inv	estigation,	, in my op	inion, deat	d place, ar h occurred	d at the time, o	late and pla	ace, and di	ue to the cause(s)
)	To To Con	Σ	29b. Signature and tille of certifier	MA			4.	24	1/:	7		. 1	_	hth, Dey, Year)
	3		30 Name and address of person who co	mpleted cause of deat 1050 32. Registrar's	5.	23a) (Туре,	Print)	5/0	1 dg	4 CK	dala	Erker S.	19/2	9, 2006 Net 21544
**	Sta Registi			2006 Magistrar's	July .	D. Ja	barti.	1						

		1 - State Amend item#18.	State of M perFH, G802						d Mental		-	C 7
		Registrar 1. Decedent's Name (First, Middle, La			Ce	rincaie	OIL	realli	2. Date		10.200	3. Time of Death
Physic	ian		,						Month		ay Year	1
/Medi		Thomas Lynn Fi 4a. Facility Name (If not institution, giv)		4b. City. T	own. or	Location of D	DECEM!		22, 200 lc. County of De	
Exami	ner	Saint Joseph			ter	, i.e. ony,	o () , () ,		NSON			ltimore
Funeral		5. Social Security Number 6. S	Sex 7. As		last birthday)	If Under 1		If Under 24 I	Hrs. 8. Date of	of Birth h, Day, Yea	9. B	irthplace (State or Foreigr Country)
Director		220-20-6576	X M 2□F	81	Yrs.	Months	Days	Hours N		12 1	925	MD
nd v		Usual Residence of Decedent 10a, State 10b, County		10c Cit	y, Town or Lo	neation						10d. Inside City Limits
aryla shov	7			100. 01								1 □Yes 🕏 □No
the N 28a-f	Director	MD Baltimo 10e, Street and Number	re		Timo	nium 10f. Zip (Code			10g (Citizen of What (
with ga or the t		660 Straffan D	r. #306				210	93			USA	
be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Decede			? (Specify Yes o	or No-	14. Race - An	nerican Indian,
after or ite		1 Never Married 3 Married	Armed Forces? 1 ☐ Yes 2 If Yes, Give			1 ☐ Yes 2		Specify:	ueno Hican, etc	:.)	Black, Wh	
ral", c	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			TLITES 4	M INO	Specify.			Specify:	white
72 h 'natu dical	Completed	15. Decedent's E (Specify only highest gra			ı (Give	dent's Usual kind of work	k done d	uring most of	working	16b.	Kind of Busines	s/Industry
ed within 72 hours af rgiene. er than "natural", or t, the Medical Exami	ם	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use	,			D1		1
D D		12 17. Father's Name (<i>First, Middle, Last</i>	<u>5+</u>		Resea	rch Cl			Name (First, M		rmaseut en Surname)	ıcaı
	o Be	Thomas E. R. F	•					Louise -Ma	Lynch rearet	Lanch	am	
s 1 and 2 should be file f Health and Mental Hy item 27 is marked oth	F	19a. Informant's Name/Relationship (Type. Print)		19b. Maili	ing Address	(Street a	nd Number o	r Rural Route N	lumber, City	y or Town, State	, Zip Code)
		Thomas Lynn Field	s,Jr./Son		228 E	. 25tl	h St	. #7,	New Yor	k, NY	10010	
		20a. Method of Disposition			Place of Disperentery, cre	osition (Nam	e of her place	9)	Date	20c.	Location - City of	or Town, State
Page nent o		1 ☐ Burial 2X☐ Cremation 3 ☐ 4 ☐ Do <u>na</u> tion 5 ☐ Other (<i>Speci</i> i		∍	tro Cr	-		i i	/27/06	Cat	onsvill	e, MD
permit. Page Department of Important: If any injury or once.		21 Signature of Funeral Service Lice	Wan W. C	lary		2. Name and		s of Facility				
e a m e e		- Ducew	() (0)	1	- 11.0	W. P.	adon	ia Rd.	Timon	i 11m .	ey vallo MD 2109	ey, Inc.
	1	23a. Part1. Enter in disease, or com shock, or have failure. List only	plications that cause one cause on each	the deat	h. Do not en	ter the mode	of dying	, such as car	rdiac or respirat	ory arrest,		Approximate Interval Between
Physician		Immediate Ca r e (Tinal disease or corr itio)									ASE	Onset and Death
/Medical		resulting in de	ue lo (or as	s a conseq	uence of):	1 4 5 5	****		CULAR	A. M. Sec. Sec.		
Examiner	١.	Sequentially list conditions,	b									
ed sit	Examiner	Sequentially list conditions, if any, leading to fininediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s is conseq	uence ot):							
be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as	s a conseq	uence of):							
be executed sician and burial-transit	cal E											
e % t			_a	-								
Jeath certificat attending phy I for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of d	lelivery
death e atte d for	icia	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 4□Pregnant a			□Ectopic pre □ Other (spe				_	Month	Day Year
t the by the ache	hys	9 ☐ Unknown	9□Unknown									
The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as the		Part II. Other significant conditions	contributing to death I	but not res	ulting in the u	underlying ca	use give	n in Part I.	23e.	Did tobacc	o use contribute	to the cause of death?
w require been sig should t	ed								_	1 Tyes	2□(No 3□	Probably 4 □Unknown
The law requires to has been signed age 2 should be o	Completed by								24a.	Was an autopsy	24b. Were	autopsy findings available o completion of cause of
	E O								1□、	performed	death'	?
ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	S						Death (Check	only one)	<u>'</u>	
Physician: rthis certific ral director,	2	1 ☐ Yes 2 ☐ No	Hospital: Inpat		ER/Outpatie			4 LI Nursii			6 ☐Other (Sp	pecify)
ding Phys h. After this	Ë	27. Manner of D ath 1 X Natural 5 □ Pending	28a. Daje of Inj (Month, D	jury <i>ay Year)</i>	28b. Time o Injury		Bc. Injury Work	?	28d. Desc	ribe how in	jury occurred	
or Attending after death. Director: Afte	Certification:	2 Accident investigatio 3 Suicide 6 Could not b		ium, - At h	omo farm et	M troot factory	-	∕es 2 □ No	205 0001	ion (Ctunot	on of Alcombon on	Dural Bouto Number
after of Direct Direct of Jin by	Ħ	4 Homicide determined	building, e	etc. (Specif	y)	ireet, ractory,	, office			or Town, St		Rural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a, Certifier 1 Certifying P	hysician: To the bes	t of my kno	wiedge, dea	th occurred	at the fir	ne, date and r	place, and due t	o the cause	(s) and manner	as stated.
To the Hospita within 24 hours To the Funeral completely filled	Medical		miner: On the basis and manner s	of examina								
omply	Me	29b. Signature and title of certifier	Λ			290.	. License	number		29d. [Date signed (Mo	nth, Day, Year)
-> - O		Joyly 1 De	oh				D a	26637			12/231	06
: ^		36. Name and address of person who	completed cause of	death (Iten	n 23a) (Type	, Print)	<u> 17 c</u>	<u></u>				
10			·	•		-	T LIE	TOUGE	<u> 181 – M</u> O		un 2120	14
S	ate	31. Date lifed (Wonth, Day, Year)		trais Signa	ature SEE	6 25 -	T A 1	i awat	IN, MA	V 1 2007 17	a day to the to	
Regis	trar	DEC 9 8	7005 Atas		18 1	constel						

06-09801 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Figter of Manyland Department of Health and Mental Hygiene Certificate of Death Daniel J. Fontaine 1. For State Reg. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Time of Deat Physician/ 2006_{Year} Month Day 2000 December 23, 2000 1500 hrs **Medical Examiner** Daniel J. Fontaine 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours oreian Min Directo Country) 1X M 2 F Sep. 17, 196 PA 213-86-7029 44 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b County à 1 Yes 2 X No or items 23a or 28a-f show Salisbury yes 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f sho Wicomico MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's at 21804 USA 205 Stone Street Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White etc. 1 Never Married 2 X Married Yes 2 X No white Black f Yes, Give Year or Dates: 1 Yes 2 No specify: white Widowed Divorced Specify: other than "natural", the Medical Examiner ģ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Trucking Ind. Truck Driver 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Alton Jordan

19a. Informant's Name/Relationship (Type, Print) Mafalda Pollitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stone Street Salisbury, MD 21804 <u> Regina Fontaine - Wife</u> 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: I injury or oth Dec. 28, 016 Baltimore, MD 4 Donation 5 Other Specify: Metro Crematory 22. Name and Address of Facility
Cremation Society of Maryland,
299 Frederick Road Baltimore, 21. Signature of Funeral Service Licensee 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Heroin intoxication and cocaine use Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last and cal AMENDED #2, perVT, G862, 12/29/06, WS // #23a, 27, 28a-f, perVE, X UNPENDED physician g863, Physician/Medi 1/10V07 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month 2 Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No After 28a Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification 1 Natural 5 Pending 1 Yes 2 X No 24 hours after death Funeral Director: unknown Fnd 12/23/2006 unknown 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 205 Stone Street 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide determined House Homicide Salisbury, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 24, 2006 30 Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Ana Rubio MD.

31 Date filed (Month, Day, Year)

Assistant Medical Examiner

egistrar's Signature

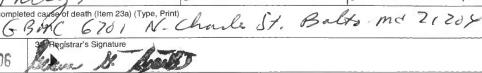
111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Physician Mary E. Fauver 2006 December • 38 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Gilcrest Hospice <u>Towson</u> Baltimore If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) (State or Foreign **Funeral** Days Hours 1 □ M 2 💢 F Yrs. 216-03-4448 Director 93 25, 1913 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director MD Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 1920 Chipper Drive 21040 United States Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Americen Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ò 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any Injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Schafer Myrtle Lowman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Joyce Balton - Daughter 4404 Hooper Avenue, Baltimore, MD 21229 Ob. Plage of Disposition (Name of Crestly grematory or other place) 20a. Method of Disposition 20b. Plage 20c. Location - City or Town, State Burial 2 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Gardens 12-26-2006 | Marriottsville, MP Cardens 22. Name and Address of Facility Ambrose Funeral Home, Inc. o Full eral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** en /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ LIVIUR 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has I autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Pother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ပို After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Hospital or Attending 1 Natural 1 Yes 2 No death. 2 Accident To the Hospital or Attenc within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 - Priffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

K. 31. Date filed (Month, Day, Year) DEC 2 8 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



December 24, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Bernita Frances Fritz 23, РМ December 2006 8:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 02-27-1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 X F 87 216-05-4834 Yrs. Baltimore, Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits Maryland Harford Abingdon 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21009 2913 Craigston Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernita Woolford Charles Eline Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Fritz - Daughter-in-Law 2913 Craigston Lane Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gardens 12-27-2006 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 6 Funeral Service Lichesee 22. Name and Address of Facility 5305 Harford Road Made Leonard J. Ruck, Inc. Baltimore, MD 21214 lune Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) a uc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) enhi Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

Physician /Medical Examiner The law requires that the death certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Examiner

Completed by Physician/Medical

Certification: To Be

Medicai

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event Since.

filed within 72 hours after death

Baltimore, Maryland 21215-0036

signed by the attending physician and d be detached for use as the burial-trar been has page 2 certificate To the Funeral Director: After this certific completely filled in by the funeral director,

or Attending Physician:

death.

within 24 hours a To the Hospital

3 ☐ Suicide

29a. Certifier

4 Homicide

27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

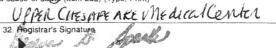
29c. License number D26344 29d. Date signed (Month, Day, Year)

ricea curu 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

BELAIR MARKLANDA

State Registrar

PATRICIA GURNY, MD 31. Date filed (Month, Day, Year) DEC 2 8 2006



			For State Registrar	State of Marylar		artment of H			Reg. N	2000	4 4 7 5
Ħ	Physicia /Medic	an al	1. Decedent's Name (First, Middle, La:	GILL		4b. City, Town, o	or Location of De	OE	CEMBER	year Year 2004	7 1100AM
	Examin Funeral Director	C.	NTNTWES A USP. 5. Social Security Number 6. S	MAL CENT		RANDA If Under 1 Year Months Days	7255D	rs. 8. Da		BALTIM 9. Birth Con	/
Maryland	a-f show	tor	Usual Residence of Decedent		ity, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 🌠 No
h with the	3a or 28.	Funeral Director	10e. Street and Number 6 Pine Run Cou			10f. Zip Code	244		10g. (Citizen of What Cor	untry?
:1 215-0036 within 72 hours after death with the Maryland	af, or iteme 2 Examiner cou	<u>م</u>	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forces? 1 Types 2 No If Yes, Give 5 6 - 5		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		(Specify Y erto Rican,	es or No- , etc.)	14. Race - Amer Black, White Africa An	e, etc.
21215-0036 od within 72 hours af	Department of Health and Mental Hygiene. Importants: if item 27 ie marked other then "naturat", or iteme 23a or 28a-f ehow spiritury or other traumatic event, the Madical Exprehent chart be nutified at gree.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 11th		(Give	dent's Usual Occup kind of work done DO NOT use retire k Dispa	during most of w d)	vorking		Kind of Business/l 11 Moto Cowar	1
Maryland	Mental Hyg arked othe stic event,	To Be C	17. Father's Name (First, Middle, Last, Otis Lee Green						t, Middle, Maide	en Surname)	_
, Mary and 2 sho	n 27 le me er traume		19a. Informant's Name/Relationship (Elvira Gill/Wi	fe	6	Pine Ru		Win	dsor M	or Town, State, Z	21244
Baltimore,	nent of He ent: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State Ga	cemetery, crei	esition (Name of matory or other pla n Fores		/28/	06 Ow		lls, MD
Balt permit.	Depart fmport eny in		21. Signature of Funeral Service Light	- (12 /1)ke	19	200 Lib	erty k	d.,	kanda1		Balto. Co. MD 21244
1760; C	hysician and hysician and hysician and hysician with prival-transit	Ical Examiner	Part 1. Enter the disease, r comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	quence of):					ISTAST	Approximate Interval Batween Onset and Death
.O. Box 68 the death certifica	ned by the attending phy detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	al death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у			23d. Date of deli Month	ivery Day Year
0 g	50		Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.	2	3e. Did tobacc		the cause of death?
of Vital Records, P.O Physician: The law requires that the	cate has been si ; page 2 should	Completed						_ 1	4a. Was an autopsy performed	? death?	topsy findings available completion of cause of
of Vita Physician:	this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2		×EH Outpatie	nt 3 DOA	26. Place of D			6 □Other (Spec	cify)
_ 5	after aner	ertification:	27. Manner of Death ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time o Injury	Wo	ryat rk?]Yes 2 □No	28d. E	Describe how in	jury occurred	
Division tal or Attending	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certific	3 ☐ Suicide 6 ☐ Could not be determined			reet, factory, office		28f. L	ocation (Street lity or Town, Sta	and Number or Ru ate)	iral Route Number,
e Hospi	24 hou	Medical		hysician: To the best of my kr miner: On the basis of examir and manner stated.							
To th	withir To th	ž	29b. Signature and title of certifier	Why mo		29c. Licen		77	1	Date signed (Month	
•	421		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	0 0	2-111	0 /0	2222		22, 200 b 21133 MYLAND
	Sta Regist	ate	CHIFF IND YNIGHO 31. Date filed (Month, Day, Year) DEC 2.8.200	32. Registrar's Sign	nature	UVILI K	VAI) K	MYDI	722570	mr mr	MYLAND

			1 - For Amend #7,8&19	a Per III	larylai g863	nd /Dep	artmen 17 JH rtificate	t of H e of L	ealth a Death	and M	ental Hy	giene Reg. No.	200	6		76
	Physici	an	1. Decedent's Name (First, Middle, La	ist)					-		2. Date of De	ath	, Y,	ear	3. Time of	Death
	/Medic		Lillian K. Gra				,				Decembe	er 15	, 200	16	2:20	Рм
	Examin	ner	4a. Facility Name (If not institution, give		r)		4b. City,		Location o	of Death		4c.	County of			
ŧ			5. Social Security Number 6.5		lao (la ura	. last birthday)	If Under		If Under:	24 Hrs	P. Data of Bi-	45			nore	
	Funeral Director			1 □ M 2 X F		87 Yrs.	Months	Days	Hours	Min	8. Date of Bir (Month, Da Dec. 2	y, Year)	210 9	Count	ace (State o ry) aryla	or ⊢oreign vi d
		-	Usual Residence of Decedent		00		<u></u>				vec. Zi	, , ,	/ 1 /	141	wight	7101
	how		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10	d. Inside C	
	99-1-98	ç	Maryland Balt	imore			Esse	X							1 🗌 Yes	2 🕅 No
	vith tr	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of Wha		•	
	death with the Maryland me 23a or 28e-f ehow rmat be notified at		1 Eastern Blue	· · · · · · · · · · · · · · · · · · ·	. C	10 10			2122		14 14		u. s			
_		Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Deceder Armed Forces 1 ☐ Yes 2 0	?	J.S. 13.	was Deced	ent of His	spanic Orig n, Mexican	gin? (Spe n, Puerto I	cify Yes or No Rican, etc.))-	14. Race Black, \	Amenca White, e		
-0036	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	•		1 ☐ Yes 2	No No	Specify:				Specify:	Wh	ite.	
5	72 hours after natural', or ite	ted	15. Decedent's E	ducation		16a. Dece	dent's Usua	l Occupa	ition	A mil committee		16b. Kii	nd of Busin			
7	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	kind of wor DO NOT us	e retired)	uring most	t of workii	ng					
7	ygier ygier ther th		8th Grade				Waitr							taw	rant	-
	tal H	Be	17. Father's Name (First, Middle, Last Louis Blische)							(First, Middle,		Sumame)			
چ	hould d Mer mark matic	P		Tuno Print)		10b Mailie	a Address	(Street o			ie Rode I Route Numbe		- T C1-	A - 78' - 6	0-4-1	
2	id 2 s ith an 27 is		19a. Informant's Name/Relationship (Fiorenza) Sandra Florenza	(Daughter)	ı						tingham					
ค์	s 1 and 2 should be filed f Health and Mental Hyg Item 27 is marked othe other treumatic event,		20a. Method of Disposition	(v dadg, v e e v)	20b.	Place of Dispo	sition (Nam	ne of			ate	-r-	cation - Cit			
Ē	Pages ment of tent: If I lury or		1 ☐ Burial 2 💆 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			cemetery, crer AUVĹEW				2/18/	2006	Balt	imaro	. Ma	นานใ av	nd
	mit.		21. Signature of Funeral Service Lice)						imunek					
מ	88 5 8		e kind		/	97	'05 Be	lair	L Road	d, Ba	ultimor	e, M	aryla	nd 2	21236	
			23a Part 1. Enter the disease, or con- shock, or heart failure. List only	one cause on each	the dea	th. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,			Approximat Interval Bet	ween
j l	Physician		Immediate Cause (Final disease or condition	. OVAK	2/A/	4 CAI	VCER	Ra	Di Ph	M	TTA	STA	1515		Onset and I	Death
	/Medical Examiner		resulting in death)	Due to (or a	s a conse	quence oi):					- / -)	<i>z.</i>				
		76	Sequentially list conditions,	b. ATRI	AL	F/15	SK/L	(1-)	710	N,						
	nted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	HYDE	2-1	SNC1	5 K									
'n	exection and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or a	s a consec	quence of):		_		0						
2/07	certificate be executed ding physicien and ise as the burial-transit	cal		d CAHGE	577	VE 1	YEA	RT	7	(2)	LUR	£				
Ď	leath certifica attending ph	Med	IF FEMALE:													
X O n	death ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Feta	al death 3 □	Ectopic pre					2	3d. Date of			/ear
-	the a	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of o	death 5∟	Other (spe	ecify)					HOTHER		, ay	021
	that the ed by detac		Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco u	se contribu	te to the	cause of d	eath?
S	w requires that the de been signed by the should be detached	d by					. •				101	Yes 2	□No 3□] Probal	bly 4 Oc	nknown
5	law req es beer 2 shou	Completed									24a. Was	an	24b Wer	e autons	sy findings :	available
D T	sician: The law s certificete hes b lirector, page 2 s	E O										rmed?	deat	h?	sy findings a	ause of
N I I	reffice	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only o		1 🗆	Tes 2	No No	
>	nysic nis ce I direc	To B	examiner? 1 ☐ Yes 2 ☐ 100	Hospital: 1 Inpai	tient 2	ER/Outpatien	t 3 DO	04	- /	rsing Hom			i □Other (Specify)		
5	Ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	jury lay Year)	28b. Time of Injury	28	Bc. Injury Work	at ?	2	8d. Describe h	now injury	occurred			
Vision	tend death tor: /	cat	2 Accident investigatio 3 Suicide 6 Could not b		-1 - 415		М		'es 2□N		201					
5	or A after Direc in by	Certification:	4 ☐ Homicide determined	289. Place of I	njury - At n etc. <i>(Speci</i>	nome, tarm, str	eet, factory,	office		2	8f. Location (S City or Tox	Street and vn. State)	d Number o	r Rural i	Route Num	ber,
	spital		29a. Certifier 1 Certifying Pt	nysicien: To the bes	t of my kn	owledge, death	occurred a	at the time	e. date and	d place, a	nd due to the	cause(s)	and manne	er as stat	het	
	To the Hospital or Attending Physician: The Its within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page:	edical	(Check only 2 Medical Examone)	niner: On the basis and manner s	of examina	ation and/or inv	estigation,	in my opi	inion, deat	th occurre	d at the time,	date and	place, and	due to t	he cause(s)
	To t To t Comp	Σ	29b. Signature and title of certifier	. /			29c.	License	number	0 -		29d. Date	signed (M	ionth. Di	ay, Year)	
	~		Devinta	[(1/4)	la	MO	1	2	7/8	88		12	-118	10	6	
1	1		30. Name and address of person who	completed cause of	death (Iter	m 23a) (Type,	Print)	- F	2/-		Sent	201	1 2		11-) _~
,	Sta	to	31. Date filed (Moran, Bay, Year)	JAMA 32. Regis	trar's Signa	ature d	o we		ace) Rend	au	2 OY	D	2/2	2
	Registr		9 8 2006	Alexander of	A Par	Lord	0									

			1 - For Stata Ragistrar	State of Ma	aryland		ment of licate of		-	giene) (16	and a second	77
			Decedent's Name (First, Middle, Last)		<u> </u>				2. Date of De		Year	3. Time of	f Death
	Physicia /Medic		Geraldine		Gill				Dicember		006	12:15	PM
	Examin	or	4a. Facility Name (If not institution, give:	11 . 1 0		D 41	D. City, Town,	or Location of Deat	h	4c. County	of Death		
	je .		MARYLAND GENERAL 5. Social Security Number 6. Sec	Hospilal	e (In yrs. las		Under 1 Year		8. Date of Bir	N/A	9. Birtho	lace (State o	or Foreign
	Funeral Director		219-38-9072	M 200 F	ρЦ		onths Days		(Month, Da	ay, Year)	Cour	M o	1
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locati	on				1	0d. Inside C	ity Limits
	filed within 72 hours after death with the Maryland Hygiene. Hygiene, insture!; or Iteme 23a or 28a-f ehow ont, the Medical Extrainer must be notified at	tor	Md N/A		Bal	tim ore						1 Yes	2 □ No
	ith the	Director	10e. Street and Number	0			Of. Zip Code			10g. Citizen of V		ntry?	
	ath w	ra	4012 Uswago	Court	5 i= 11.0	40.14	2121	5		<u>US</u>		an Indian,	
40	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent I Armed Forces? 1 Yes 2 No.		If Ye	s pecify Cul	Hispanic Origin? (S can, Mexican, Puer	to Rican, etc.)	Blac	k, White,		
<u> </u>	ours aft	by	3 Widowed 4 Divorced	1 Tyes 2 N If Yes, Give Year or Dates:		1 🗆	Yes 2 No	Specify:		Specify	Bb	cK	
5.0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Decedent (Give kind	d of work done	during most of wo	rking	16b. Kind of Bu	isiness/In	dustry	
₹ ∑	within ene. then	ldmo	Elementary/Secondary (0-12)	College (1-4or 5	+)		NOT use retire			MTX H		C	
, D		a l	17. Father's Name (First, Middle, Last)			11045	E reach	T	me (First, Middle	, Maiden Surnan	ouse (a)	Clean	IINQ
Ne.	o	To B	7	ucher	Sr.			Doro	my Lee	Harris	3		
and and			19a. Informant's Name/Relationship (Ty	pe, Print)	4	_	A	t and Number or Re		14150 10	25A777.0%		
of 6	s 1 and if Health item 27 other tr		20a. Method of Disposition	/	20b. Plac	e of Disposition	n (Name of	go Court	Baltin	20c. Location -	212 City or To		
Secol Baltimore	S to to to to to to to to to to to to to		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	lemoval from State	сеп	netery, cremato	ory or other pla	1				M 4	
\$ E	permit. Pag Department Important: I eny injury o		21. Signature of Lineral Service Lic is	00	Arb	22. N	ame and Addr	ess of Facility Cr	atman-	HOYELS +	uNeia	1 Hom	ı
"	Depa Impo eny is		Der Ft	the		524	O Reis	ters-town	-Bd P	altimor	L Ma	1 2121	15
		2	23a. Party. Enter the disease, or compleshock, or heart failure. List only or	ications that caused ne cause on each lir	the death. ne.	Do not enter the						Approximat Interval Bet	te tween
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	/Medical Examiner		resulting in dealth)	Due to (or as		1	٨.	ARDIO	1100 1	F 4			
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4	cuted	Examiner	that initiated events	disea	se								
0	cate be executed by sician and the burial-transit		resulting in death) Last	Due to (or as	a conseque	nce of):							
8760	cate b physic the b	edical		d							-		
Box 68	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome						23d Dai	e of delive	arv	
ğ	death e atter d for u	Physiclan/M	in the past 12 months?	1☐Live birth 4☐Pregnant at			opic pregnand her (specify) _	Çy		Mo		*	Year
0	that the ded by the detached	hys	9 Unknown	9□ Unknown									
S. S.	ires tha signed d be del	þ	Part II. Other significant conditions con	ntributing to death b	ut not resulti	ing in the unde	rlying cause g	iven in Part I.		tobacco use cont Yes 2□No	ribute to th 3 ∏ Prob		death?
Division of Vital Records.	w require been signal	Completed							24a. Was				available
e e	he law e has age 2 s	dmo							auto perfe	ormed? 🛌 📗 🤇	leath?	psy findings mpletion of c	ause of
<u></u>	an: Trifficat	0	25. Was case referred to medical			· · ·		26. Place of De	1 ☐ Yes ath (Check only		☐ Yes	2LI NO	
>	hysici nis cen	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	lospital: 1 Inpatie	nt 2 EF	VOutpatient	3□ DOA O	ther: 4 🗍 Nursing I	Home 5□Resi	dence 6 Oth	er (Specif	y)	
<u> </u>	ding Physician: The h. After this certificate h. funeral director, page	iuo	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju- (Month, Day	ry y Year) 2	8b. Time of Injury	28c. Inju		28d. Describe	how injury occur	ed		
	death death ctor: ,	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	urv - At hom	e. farm. street		Yes 2 No	28f. Location (Street and Numb	er or Rura	l Route Num	nher
, <u>``</u>	effer Direction	Certification:	4 Homicide determined	building, etc	c. (Specify)	-,, -,,	vaccory, ornoc		City or To	wn, State)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours elter death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	ner: On the basis of	examinatio	edge, death od	curred at the tigation, in my	ime, date and place	e, and due to the	cause(s) and ma	nner as st	tated.	s)
	the thin 2, the find	Med	29b. Signature and little of certifier	and manner sta	ated.			ise number		29d. Date signe			
	Z X X		Mal	le.	212	n . n	0.0	591		12 - 2			
-	7		30. Name and address of person who co			3a) (Type, Prir		211		1-2	-		
_	()\ \(\)		Alkinwumi Oladu	INNI OLA	MD		ARYLA	nd Gene	sal Hos	spital			
	Sta Registi		31. Date filed (Month, Day, Year) DEC 2. 8 20	32. Registr	ar's Signatu	re '	AND D			*			

			For State Registrar	State o	f Marylar		artment o				g. No.2 ()	06	41478
	Dhusiai		1. Decedent's Name (First, Middle	, Last)						2. Date of Death Month	Day_	Year	3. Time of Death
	Physicia /Medic		Anna	Mae		Grei				Vecember		006	9:00 P.M.
	Examin	er	4a. Facility Name (If not institution			4		wn, or Location			4c. County		1 . 1
			Baltimore Washi 5. Social Security Number	ngton Med	7. Age (In yrs.			Burnie	der 24 Hrs.	8 Date of Birth	Anne		
	Funeral Director		212-22-2776	1 □ M 2 T□ F	7.798 (7.778.	-		Days Hou		8. Date of Birth (Month, Day, Dec. 28,	Year) 1926	Coul	place (State or Foreign ntry) MD
	ט		Usual Residence of Decedent										
	arylan show	<u>.</u>	10a. State 10b. County			ity, Town or L							10d. Inside City Limits 1 ☐ Yes 2 XNo
	Ba-1 o	ecto		rundel	GL	en Bur				10	g. Citizen of	Mhat Cau	
	with th	吉	10e. Street and Number				10f. Zip Ci			10	U.S.		nuyr
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	Funeral Director	320 Wende Way	12. Was Dec	edent Ever in U	J.S. 13.			Origin? (Spe	ecify Yes or No- Rican, etc.)			can Indian,
(0	ufter d or Itan	Fun	1 Never Married 2 Marr	Armed Fo	rces? 2 🔯 No		If Yes, specify 1 ☐ Yes 2	+		Rican, etc.)		ck, White, fy: Whi	
Š	ours a	d by	3 Widowed 4 Divorced	If Yes, Gi Year or D	ve ates:		TE Tes 24	No Spec	ciry;		Speci	y: W112	
2	within 72 hours after ene. then "natural", or Ita he Medical Examina	Be Completed by	15. Deceden (Specify only highe	t's Education at grade completed)		16a. Dece	dent's Usual (kind of work of DO NOT use	Occupation done during retired)	nost of work	ing 1	6b. Kind of B	lusiness/In	dustry
4 5	withir ene. then he Ms	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		naker	100100)			Own Ho	me	
and 212	Hygi Hygi other	e C	17. Father's Name (First, Middle,	Last)				18. Me	other's Name	e (First, Middle, M			
₹ ja	uld be Jenta rked tic ev	To B	George Wiechert					Має	s. W	eber			
子, ANNA Maryland 21215-0036	2 sho and I	i	19a, Informant's Name/Relations			1				al Route Number,		, State, Zij	Code)
	and lealth m 27		MR. Leonard Gre	eig Jr. /H		_				rnie, MD	21061 Oc. Location	City or T	own State
GRE10	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if time 27 is marked other then "natural; or Itame 23a or 28a-f ehow eny injury or other traumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State I		osition (Name matory or othe		Dec 1	43,			
Hi &	it. Pa irtmer irtant njury		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service		Ci	-	ake Cre			ngleton :	Steven		
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. 0	nlma	nan	PG	lon-	4				Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):	1		/s				
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′	be executed icien and burial-transit	Exa	resulting in death) Last	C. Due to	(or as a conse	quence of):	Inches	,				i	
3760.	0 00	cal		d								-	
99	artifica ling pt e as t	Med	IF FEMALE:	00- 11				-					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Year Gracey, Gary Neal Sr. December 23, 2006 9:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2110 Merritt Blvd. Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⋤M 2□F Yrs 216-30-6760 Director Feb. 10,1935 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified Director Baltimore Dundalk 1 TYes 2 XNo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 2110 Merritt Blvd. Funeral 21222 United States death v items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced 'natural', White Korea Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ith and Mental Hygiene.

27 Is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Steel Worker Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Magillicutty ပ္ William Gracey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau once. Mrs. Sally Ann Gracey (Wife) 2110 Merritt Blvd. Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 12/27/2006 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licenses 7922 Wise Ave. Dundalk, Maryland Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician con disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed NION and resulting in death) Last Due to (or as consequence of) Box 68760, physician s the burial Physician/Medical anding l 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) signed by the a Ö 9 I Inknown 9 Unknown Division or Vital Records. P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No Probably 4 ☐Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy page formas smokes certificate Physician: 25. Was case referred to medical Be funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient Certification: To 3□ D0A 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ∏ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral Completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

DHMH 17 Rev 1/2001

State Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8/Vd

32. Registrar's Signature

White

29c. License number

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29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #20b Per TH 6862 12/28/06 Tin to Health and Mental Hygien 2 UU 6 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200 Hynson 25 Terrance De C /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Roundo //S TOWN
Year If Under 24 Hrs. 8. Date of Birth
Min. (Month, Day, Year) 5401 Old Cert Rd. Ka Hospita Battimer Northwest 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 100M 2□F Months Days 215-80-0372 9 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic event, the Madical Examinar must be notified at once. 1 ☐ Yes 2 X No MD. Directo 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Itema 23. 2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SABLED SPECIAL EDUCATION (O 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MILTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILTON HUN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility I-UNER, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary **Physician** Em bolus /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Certification: To Be Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Dey, Year) D0029488

State Registrar Eugens

31. Date filed (Month, Day, Year)
DEC 2 8

Old court Rd. #300

Pikesville MD 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000

32. Registrar's Signature

Meyer mo

2006

06-09772		Please Type or Print in Black Indelible Ink.			ble.	
Dana Harrell		State of Maryland / Department of Hea			200	6 4 1 4 8
Physicia		Registrar 1. Decedent's Name (First, Middle, Last)		Reg 2. Date of Death	No	3. Time of Death
Medical Examin		Dana Harrell		Month December 2	22, 2006 Year	2154 hrs
		,	/, Town, or Location of Death timore		4c. County of Deat	1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Ui	nder 1 Year If Under 24Hrs.	8. Date of Birth		thplace (State or
Director		212-84-4051 1AM 20F 39 Yrs. Mor	nths Days Hours Min.	July 6,	1967 Foreign	ountry) WID
any	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene int. If item 27 is marked other than "natural", or items 23a or 28a-f shown rother traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. 2	Zip Code 2/2/7		Citizen of What Could Strate St	ntry?
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ter death ", or iter		1 Yes 2 No	2 7 No specify:		Specify: B	lack
2 hours afte "natural", [Examiner	g p	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usu	ual Occupation (Give kind of w		6b. Kind of Business	Industry
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ore, MD 21215-003 es I and 2 should be filed with of Health and Mental Hygiene If iten 27 is marked other ti ther traumatic event, the Med	Be Co	17. Father's Name (First, Middle, Last) Donald Harrell	18 Mother's Name	Form	490	
D 21 should and Mer 7 is man	P	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre 1213 E	ess (Street end Number or F	Bulto	_	
e, MD 2 and 2 shou fealth and N item 27 is n	ŀ	20a. Method of Disposition 20b. Place of Disposition (N			20c. Location - City or	1
altimore, mit Pages I ar partment of Hee pportant: If ite ury or other tr		1 Burial 2 Cremation 3 Removal from State crematory or other pla 4 Donation 5 Other Specify:	, / 2	29,200	Belto,	MO
alti mit parter ports ury o		21. Signature of Funeral Service Licensee // 1 22. Name a	and Address of Facility.	MANS'	FS, AG	4
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3760 ficate b g physi	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of deliver	y Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medical	past 12 months? 4 Pregnant at time of death 5 Other (S		,		
the dea ry the a	Phys	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underly	ving cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execu within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tre	by			1 Yes	2 No 3 Pro	bably 4 Unknown
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Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, fact	tory, office building, etc.		reet and Number or R	ural Route Number, City Lton Avenue
Dispital cours a neral l'filled	Cert	4 Homicide determined (Specify) found on porch of re		Baltimore,	MD	
he Ho in 24 h he Fu	ical	29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in	the time, date and place, and my opinion, death occurred a	due to the cause at the time, date ar	(s) and manner as sta nd place, and due to t	ted. ne cause(s)
To t To t	Medical	and manner stated	29c. License number		29d Date signed (Mo	
	1	/// 1 - 1 -	O.C.M.E.		December 23, 2	006
	1 8	30. Name and address of person the completed cause of death (Item 23a)	01 1 5 111	ID 04004		
4	er 15	The state of the s	nn Street, Baltimore, N	21201		
S Regis	tate trar	31. Date filed (Month Day Year) 32. Fegistrar's Signature				

Registrar

		Physici		1. Decedent's Name (First, Middle, Last)		Month D	ay Ch 100/0	3. Time of Death
4	,	/Medic Examir		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	1 - 7
		- Admini		Bultimore Washington Medical Center	GlenBurnie	6	Inne A	rundel
0)		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 2 2 0 2 1 5 1 1		Date of Birth (Month, Day, Year	9. Birth Cou	place (State or Fore
9.		Director		212-30-3151 ¹₩ ^{M 2□F} 73 Yrs. Usual Residence of Decedent		Dec 29, 19	932 <u>Mar</u>	yland
1000 m		nyland how	_	10a. State 10b. County 10c. City, Town or Loc	Pasadena			10d. Inside City Lim
9		Ba-f	Director	Maryland Anne Arundel		40-0	(h) (100) 1 C	1 ☐ Yes 2 🛣
2		72 hours after death with the Maryland natural', or iteme 23a or 28a-f ahow disal Examinat must be notified at	ai Dir	7828 Bertha Rd.,	10f. Zip Code 21122	10g. C	itizen of What Cou USA	ntry?
Œ		er des	by Funerai		Vas Decedent of Hispanic Origin? (Spec i Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	 Race - Ameri Black, White, 	
TOT HAUS	920	urs aft	by F	1 Never Married 2 Married 1 Mayes 2 No If Yes, Give 1 Year or Dates: Korea	☐ Yes 2 No Specify:		Specify: Whi	Lte
1	215-0036	72 ho	sted	15. Decedent's Education (Specify only highest grade completed) (Give (Give)	ent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. l	Kind of Business/Ir	idustry
土	2121	within ane. than	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Notor Operator		Continent	al Can
		Hygid other	e Cc	17 Father's Name (First Middle ast)	18. Mother's Name (First, Middle, Maide	n Sumame)	
	/lan	Wenta Wenta Irkad Ittc av	To B	George J. Holthaus	Cather	ine Leach		
	Maryland	od 2 shouth and 1		G T TT 1.1	g Address <i>(Street and Number or Rural)</i> 88 Bertha Rd., Pasa		or Town, State, Zip 21122	o Code)
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "naturat", or itema 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examinar must be notified at 2056.		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify)	sition (Name of place) Da patory or other place) rematory, Inc. 12/		ocation - City or Tolling - Ci	
	Baltin	permit. F Departmi Importar any injui		21. Signature of Fuperal Service Licensee	Came and Address of Facility Fun O4 Mountain Road,	eral Home	, P.A. Md. 211	122
•	Box 68760,	death certificate be executed a ettending physicien and id for use as the burial-transit	dicai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ar the mode of dying, such as cardiac or			Approximate Interval Between Onset and Death Oscillation (Control of the Control
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		w requires that the de been signed by tha should be detached	d by Physi	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.			the cause of death?
	Division of Vital Records,	The la sete has page 2	Completed			24a. Was an autopsy performed?	death?	opsy findings availa ompletion of cause of
	VIE S	certifice irector, p	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (
	o t	ding Physician: n. After this certific funeral director,	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	4 Nursing Home	d. Describe how inju		Y)
	rision	Attending death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	M t ☐ Yes 2 ☐ No	f. Location (Street a	and Number or Run	al Route Number.
	á	oital or , urs aftar real Dire		4 ☐ Homicide building, etc. (Specify)		City or Town, Sta	te)	
		To the Hospital or Attend within 24 hours after death or To the Funeral Director: / completely filled in by the fi	edicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death part of the basis of examination and/or invariant and manner stated.	occurred at the time, date and place, an restigation, in my opinion, death occurred	d due to the cause(s) and manner as s nd place, and due t	stated. o the cause(s)
		To the comp	Σ	29b. Signature and title of certifier	29c. License number	A	ate signed (Month,	
8		, 1		Mario Pallaco Mas	0003274	7 1700	1 Mamo	9 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 🛣 No

use contribute to the cause of death? □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 6 ☐Other (Specify) y occurred d Number or Rural Route Number. and manner as stated. place, and due to the cause(s) no completed cause of death (Item 23a) (Type, Print) 301 32. Registrar's Signature **ORIGINAL**

Registrar

31. Date filed (Month, Day, Year)

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 4 484 State of Maryland / Department of Health and Mental Hygiene UUb Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 1:30 P M Hughes December 25. 2006 Ray /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 714 East Shore Road Pasadena
If Under 1 Year | If Under 24 Hrs. | Anne Arundel Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 117M 2∏ F Yrs. Director 233-18-8064 88 March 20,1918 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Pasadena Direct 10f. Zip Code 10g. Citizen of What Country? 714 East Shore Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) other then College (1-4or 5+) .8. N/ACrain Operator Beth Steel Corp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked ဥ Awanda Myrtle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tem 27 i <u>Katherine M. Hughes (Wife)</u> 714 East Shore Road Pasadena. Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 = 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 12/27/06 Baltimore, Maryland 21. Signature of Funegal Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ongestiv /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 1 Yes 1 Yes Division of Vital director, 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27 Manner of Peath 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signatu and title at certifier 29c. License number 29d. Date signed (Month, Dey, Year) ss of person who completed cause of death (Item 23a) (Type, Print) 050

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

28

2006

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 **Physician** 11:48 P M Margaret Joan Harrison 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F 88 6-9-1918 Director 212-52-1581 England Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Bethesda 1 ☐ Yes 2 No Montgomery Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If then 27 Is marked other than "network any highy or other traumating." 4877 Battery Lane #708 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 Mar No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Percy Harold Leadbeater Marion Bates 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Harrison/daughter <u>5218 Danbury Rd. Bethesda, MD 20814</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory | 12-26-2006 | Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Svc933 Gist Ave 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Heart Failure. sestive **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼ No 24a. Was an autopsy performed 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this Hospital or Attending Pl 24 hours after death. Funeral Director; After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 XNatural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier 🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Harrison, Margaret 12423 love 11:48 pm

ECS Chy 400

31. Date filed (Month, Day, Year)

DEC 28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHYETO (M. ELSHYYHO) Medical

32 Registrar's Signature

06-09713 Everton Holder

Please Type or Print in Black Indelible Ink.	Encure All Copies Are Legible
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ertori i ioidei		1-For State Registrar	ertificate of De		u wenta	· -	g. No. 2006	5 4 1 4 8 (
Physici edical Exami	an/	Decedent's Name (First, Middle,Last)	older			2. Date of Death Month December		3. Time of Death 1300 hrs
		4a Facility Name (if not institution, give street and number)	4b. Či	ity, Town, or	Location of		4c. County of Death	
Funeral		Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs		altimore Under 1 Yea	r If Under	24Hrs. 8. Date of Birtl	N/A n(MM/DD/YYYY) 9. Birt	hplace (State or
Director		219-39-3659 1XXM 2 F 41	Yrs. Me	onths Day	s Hours	Min. 8 20	1965 Foreign	n ^{Intry)} Jamaica
w any		10a State 10b. County 10c. Ci	ity, Town or Location					10d. Inside City Limits
ryland a-f sho	ctor	MD N/A 10e. Street and Number	Baltimore 106	. Zip Code			g. Citizen of What Coun	1 X Yes 2 No
ith the Maryland 23a or 28a-f show any notified at once.	al Director	1805 Ingram Road	140 140 110 1	2123			USA	Disali
r death wi or items	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, sp	pecify Cubar	n, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	White, etc.	
ours afte	þ	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)) 16a. Decedent's Us		tion (Give kir		Specify: B1.	ack ndustry
1215-0036 Id be filed within 72 hours after Mental Hygiene narked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th 2yrs	during most of Everead	•		,	Self empl	oyed
5-0036 iled within 7 Hygiene I other than the Medica		17. Father's Name (First, Middle, Last)			18.Mother's	Name (First, Middle, M	laiden Surname)	
2121; ould be fil I Mental I: marked ic event,	To Be	Dudley George Holder 19a Informant's Name/Relationship (Type, Print)	19b. Mailing Add	ress (Stree		utrice er or Rural Route Numl	Morgan ber, City or Town, State,	Zip Code)
MD and 2 show alth and m 27 is aumatic	_	Tami Holder-wife				Baltimore,		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Fleath and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 3xBurial 2 Cremation 3 Removal from State	b. Place of Disposition (crematory or other plankwood Co	ace)	,	Date 12/28/2006	20c. Location - City or Baltimore	,
Balti permit. Departm Imports injury o		21. Signature of Funeral Service Licensee A Lady ware	\	and Address	•	MARCH FUI Avenue Bali	NERAL HOME- timore, MD	EAST 21202
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the dea failure. List only one cause on each line.		ode of dying,	such as car	diac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wood Due to (or as a consequence)						- Dodnii
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	e of):				_	
uted nd ransit	l Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence d	e of):					
'60, ate be executed bhysician and re burial - transit	Medical	CECNEMU XMENDED						
(e \frac{1}{2} &		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pr 1 Live birth 4 Pregnant at time of	2 Fetal de		Ectopic p	pregnancy	23d. Date of delivery Month D	ay Y ear
Box 687 e death certific the attending	Physician/	1 Yes 2 No 9 Unknown 9 Unknown)x
;, P.O. ires that the signed by 1	by	Part II. Other significant conditions contributing to death but no	ot resulting in the underl	lying cause (given in Part		pacco use contribute to t	
of Vital Records, ing Physician: The law require After this certificate has been si tuneral director, page 2 should b	Completed					24a. Was a autops	sy prior to co	opsy findings available ompletion of cause of
Rec	Com			00 Pi	- 6 D 15 (G	perform		s 2 No
Vital ysician his certi director	o Be	25. Was case referred to medical examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2	✓ ER/Outpatient 3	DOA	Othor	Nursing Home 5 F	Residence 6 0ther:	
on of anding Photh	-	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month Day Year) Dec 20, 2006	28b. Time of Injury 1238 hrs		ry at Work? Yes 2 ✔ N	Subject shot	ow injury occurred	
Division of Vital ral or Attending Physiciam: rs after death al Director: After this certis led in by the funeral director	Certification:	Suicide Could not be determined (Specify) Local Sta	t home, farm, street, fac	ctory, office b	ouilding, etc.	or Town, St	treet and Number or Rur ate) yette St., Baltimore, N	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death the Prince of the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical Ce	29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examination	ledge, death occurred a			e, and due to the cause	e(s) and manner as state	d.
To with To	Mec	and manner stated. 29b. Signature and title of certifier		29c. Licens			29d Date signed (Mon	
		CarolHallar	tom 220)	O.C.	M.E. 		December 21, 20	06
12		30. Name and address of person who completed cause of death (Itu Carol Allan, MD Assistant Medical Examiner	111 Penn Stree		ore, MD 2	21201		
S Regis	tate trar	31. Date filed (Month Dev. Year) 8 2001 32. Registrar's Sign	12 11 12 11 11 11 11 11 11 11 11 11 11 1	A Stanford				

		1 - For State Registrar	State of Ma		d / Dep		nt of H	lealth a	and M		giene Reg. No.	•	, 4	1487
Physic	ian	Decedent's Name (First, Middle, L.	EVELYN	VTOI	г. д Н т	гт.т.				2. Date of De Month	Day		ar	Time of Death
/Medi Examir		4a. Facility Name (If not institution, gi					, Town, or	Location	of Death	12	40.	County of D		7 - 1
pri l	4	CARROLL HOSPIT	AL CENTE	R			WES	TMIN	STER			ARRO	LL	
Funeral			Sex 7. Ag 1 ☐ M 2 ☐ F		st birthday, Yrs.		r 1 Year Days	If Under Hours		8. Date of Bir (Month, Da	th			(State or Foreign
Director		215-26-2220 Usual Residence of Decedent	Λ	78	113.					1/21/1	928	MZ	RYL	AND
ryland		10a. State 10b. County			, Town or L									nside City Limits
Sa-f s	ecto	MD CARRO	7T		WEST									1XYes 2 □ No
with ti	Dir	10e. Street and Number 121 VIRGINIA	AVE.				p Code 2115	8		,		zen of What JSA	Country?	
death ms 23	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S	6. 13.				gin? (Spe	crfy Yes or No Rican, etc.)		I4. Race - A	merican Ir	ndian,
laryland 21215-UU36 2 should be tiled within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23a or 28a-f show aurnatic event, the Medical Examinat must be notified at	y Fur	1 Never Married 2 Married	Armed Forces? 1 Yes 2 1 If Yes, Give			1 Yes, spe				Rican, etc.)	1	Black, W		
ZTZT5-UU36 d within 72 hours aff glene. or than "naturel", or the Medical Exerti	ed by	3 Widowed 4 □ Divorced 15. Decedent's E	Year or Dates:		16a. Dece	dent's He	ial Occupa	ation				Specify: W		
Onin 72	Completed	(Specify only highest gi Elementary/Secondary (0-12)	ade completed) College (1-4or 5	54)	(Give	kind of we	ork done d	during mos	t of workin	ng	100, Kii	id of Busine	SSIIIGUSTI	у
000	Com	12		, ,		PR	ESSE	R			SEW	ING F	'ACT	ORY
Maryland d 2 should be file th and Mental Hy to 1s marked oth traumatic event	Be	17. Father's Name (First, Middle, Las	MES L. M	ENCU	EV (CD				(First, Middle				
aryla should nd Men r marke	은	19a. Informant's Name/Relationship		ENCIL			s (Street a		RACE	Route Numb		JONTZ		(a)
Nd 2 salth ar allth ar 27 ts		LINDA C. SHIPL	**	HTER										
Ore, es 1 a of Hei fitem rothe		20a. Method of Disposition		20b. Pla	ace of Disponentery, cre	osition (Na	me of		D	ate		cation - City		
altimore, mit. Pages 1 a partment of Hea portant: If item y injury or othe		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Speci	fy)	LEI	STER	's c	EMET	rery	12/	27/06	WES	TMIN	STER	, MD
Baltimore, Maryla permit. Pages 1 and 2 should Impoparment of Health and Men Important: If tem 27 is marke eny injury or other traumatic once.		21. Signature of General Service Lice	nsee		2	2. Name a	nd Addres	s of Facilit	FLE	TCHER	FUN	ERAL	HOM	E
		23a. Part1. Enter ne disease, or con	nolications that caused	the death.						WEST!		TER,		∠1157 proximate
Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.				g, 000. 20	04.0.00	. copilatory a	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Inte	rval Between set and Death
/Medical		disease or condition resulting in death)	a Superior (or as	a conseque	ence of):	Em	16						DO	345
Examiner	_	Sequentially list conditions, if any, leading to immediate	b											
ted nsit	Examiner	Cause (Disease or injury	Due to (or as	a conseque	ence of):									
/ 6U, te be executed ysician and te burial-transit	Exar	that initiated events resulting in death) Last	C. Due to (or as	a conseque	ence of):									
3 5 5 8	cal		_ d								-			
. BOX DB death certificat e attending phy d for use as th	Med	IF FEMALE:												
BOX Bath cerr attendin for use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3[⊒Ectopic p ⊒ Other (s)					2	3d. Date of o Month	delivery Day	Year
	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown	time of dea	atri 5t	_ Othai (s)	оөспу)							
The law requires that the de tie has been signed by the a	by PI	Part II. Other significant conditions	contributing to death b	ut not resul	ting in the u	inderlying (cause give	n in Part I		23e. Did t	obacco us	e contribute	to the ca	use of death?
w require		C. DIFICIL	E ENTE	RIT	15					10	Yes 2	\$\\o 3□	Probably	4 Unknown
VICAL RECONDS, sician: The law requires to certificate has been signe frector, page 2 should be c	Completed	CARCINO	A OF -	THE	· 6	- ام در	106	US		24a. Was autop	osv	prior	to complet	indings available
		PNEUmi								1 Yes		death 1 🗆 Y	es 2	No
Or VICA Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ot 10 E	:D/Outo at on	- 200	Othe			(Check only o				
	n: To	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time o		28c. Injury Work	at		ne 5 🗆 Resid 8d. Describe l			pecity)	
Attanding For death. Ctor: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	n	y 10a1)		М		res 2 🗆	No					
- 5 E E C	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ury - At hon c. <i>(Specify)</i>	ne, farm, st	reet, factor	y, office		2	8f. Location (S City or Tox	Street and vn, State)	Number or	Rural Rou	ite Number,
To the Hospital of within 24 hours at To the Funeral Completely filled it	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysicien: To the best of miner: On the basis of and manner sta	examination	rledge, deat on and/or in	h occurred vestigation	at the tim	e, date an pinion, dea	d place, a th occurre	nd due to the d at the time,	cause(s) a date and p	and manner place, and d	as stated.	cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier	/	^		- 1	c. License					signed (Mo		
.1		Lineat	fare	- / T	ms)	DO	166	3	MA	13	1/25	106)
4		30. Name and address of person who			23а) (Туре,	Print)	4	447	E	MA	\sim	STA	EET	_
Sta	ite_	31. Date filed (Month, Day, Year)	32. Registra	⊂ ౖౖౖౖౖ ar's Signatu	nte lo	2		NES	Ton	NOTE	= R	mis	717	57
Registr		DECOR	2006		Es A	1	A							

			1 - For State Registrar	State of Marylan	-	artment <i>tificate</i>			ind M	-	giene Rog. No.	1112	41488
4	Physici /Medic	al	Decedent's Name (First, Middle, Last) MIRIAM		НА	WTOF			4 Dooth	2. Date of De.	Day	11 20	06 5 Ann
	Examin	er	4a. Facility Name (If not institution, give str LEVINDALE HEBREW H				ГІМО	RE			4c.	County of E	N/A
gri.	Funeral Director		211 00 1333	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bin 05/21/	1934	9.	Birthplace (State or Foreign Country) MD
	nyland how		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo								10d. fnside City Limits
	death with the Maryland me 23a or 28a-f show Littust be notified at	Director	MD N/A 10e. Street and Number		BALT	IMORE	Code				10a. Citi	zen of What	1 X Yes 2 No
	ath with		2434 W. BELVEDERE					21215					USA
036	hours after de turei', or iteme al Exementin	d by Funerai	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 M No ff Yes, Give Year or Dates:	l II	Vas Decede fYes, specif I□Yes 2		spanic Origin, Mexican, Specify:	jin? (Spe , Puerto I	cify Yes or No Rican, etc.)			merican Indian, Yhite, etc. WHITE
7-61717	d within 72 h giene. ir then "natu	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	lent's Usual kind of work DO NOT use STERE[done du retired)	uring most	of workii	ng		nd of Busine	ess/Industry
yiand	Mental Hygarked other	To Be C	17. Father's Name (First, Middle, Last) JOSEPH		HAWT	0F		18. Mother		(First, Middle,	Maiden	Sumame)	GLICKSON
Mar	nd 2 shoulth and 27 lam		19a. Informant's Name/Refationship (Type JOYCE HAWTOF / NIE							OKLYN,			e, Zip Code)
ore,	iges 1 au nt of Hea if item or othe		20a. Method of Disposition 1 🕅 Buriaf 2 ☐ Cremation 3 ☐ Ren		lace of Dispos					ate			or Town, State
aitill	mit. Pa pertmer portant: y injury Ce.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	CIA	B SHAL	UM MEN . Name and				5/2006 LEVIN:			FOWN, MD S., INC.
מ	88118		23a. Part1. Enter the disease, or complica	utions that caused the death					WN F	ROAD - 1	PIKE		MD 21208
8/00,	Physician and Image of the private o	dical Examiner	shock, or heart faifure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last d	Due to (or as a consequence to (or a))).	uence et):	arla	He	re	les.	ful	lun c		Interval Between Onserand Death Yell Yel
O. BOX 6	the death certificate y the attending phys ched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent profinant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	. If yes, outcome of pregna. 1 □ Live birth 2 □ Fetaf 4 □ Pregnant at time of de	death 3	Ectopic pred Other (spec			,		2	23d. Date of Month	delivery Day Year
ras, r.	requires that the de een signed by the a nould be detached t	by	Part fl. Other significant conditions confin	buting to death but not resu	ulfing in the ur	nderlying cau	use givei	n in Part I.				se contribut	e to the cause of death? Probably 4-JUnknown
ai Mecords	The law ete has b page 2 sl	Completed										24b. Were prior death	
or vital	Physicien: this certific ral director,	То Ве	1 105 2/ 100		ER/Outpatien		Cthe	4 □ Nur		<i>(Check only o</i> ne 5□ Resid		Other (S	Specify)
lon	tending P death. tor: After the funera	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of fnjury	M 280	c. Injury Work?	at ? es 2 □ N		8d. Describe h	now injur	y occurred	
DIVISION	To the Hospitel or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	′)					City or Tow	vn, State,)	Rural Route Number,
	te Hosp 24 hou e Fune. letely fil	edical	29a. Certifier 1	rian: To the best of my known of the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at restigation, in	the time n my opi	e, date and nion, deatl	d place, a h occurre	and due to the old at the time, o	cause(s) date and	and manner place, and	r as stated. due to the cause(s)
1	To th To th comp	Me	29b. Signature and title of certifier	· m			License		1			_	onth, Day, Year)
į	, h/		30. Name and address of person who com	pleted cause of death (Item	23a) (Type, I	Print)	746	(& -			<u> </u>	2	Himase MD
	Sta	to	31. Date filed (Month, Day, Year)	em 2 32. Regisfrar's Signal	434	から	el	red	ere	au	2	1391	himore MD
34	Registr	- 1	DEC 2 8 2006	Person S.	Book	Be B							

06-09719	
Cheryl D.	Harris

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No. Registrar 2. Date of Death Physician/ Decedent's Name (First, Middle Last) 3. Time of Death Month Day December 20, 2006 1607 hrs Medical Examiner CHERYL D. HARRIS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore St. Agnes Hospital N/A If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Funeral Min Months Davs Hours Director Country) M 2 X F 04/14/1962 220-82-6445 Md. 44 Usual Residence of Decedent 10d. Inside City Limits JIIV 10a. State 10b County 10c. City, Town or Location 1 X Yes 2 No 28a-f show N/A Baltimore Md nours after death with the Maryland rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country notified at USA ā 2605 Elsinore Avenue 23a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 2 X No Yes Yes 2 X No specify. Specify: Black Widowed 4 Divorced If Yes, Give Year Ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) s 1 and 2 should be filed within 72 ho f Health and Mental Hygiene. If item 27 is marked other than "na er traumatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Comple Homemaker Own Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Nelson Trust Joan Lee it Pages I and 2 should be timent of Health and Ment retant: If item 27 is mark y or other traumatic even 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Harris Md.21216 2605 Elsinore Avenue, Baltimore, 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 12/26/2006 Metro Crematory Catonsville, Md. Donation 5 Other Specif ² Name and Address of Facility Estep Brothers Funeral Service -1300 Eutaw Place, Baltimore, M ture of Funeral Service Ucens $^{\mathrm{PA}}_{21217}$ Йď. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval art I. Enter the disease, or complications that caused **Physician** Between Onset and failure. List only one cause on each line /Medical Death End stare disease and hypertensive cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED AMENDED attending physician or use as the burial #23a,PII,27,perME, g863, 1/31/07 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Diabetes mellitus Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? 1 🗸 Yes ✓ Yes 2 2 No 25. Was case referred to medical 26 Place of Death (Check only one) the Hospital or Attending Physician: Be Other₄ Hospital: 2 FR/Outpatient 3 DOA Nursing Home 5 1 Ves After t 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 Pending Director: 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the l 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 22, 2006 Lo 30. Name and address of person who completed dause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD.

DHMH 17 Rev 1/2001 OCME 2006

State Registra

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 19 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Vear 17 Sarah Harrod ZUX /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimor If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F Director 214-20-2672 Jun 5, 1914 Maryland Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show at be notified Director 1 TXYes 2 □ No **Baltimore** Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 "natural", or items 23a 5213 Fredcrest Road 21229 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 BNo Specify: ģ Specify: 3 AWidowed 4 □ Divorced **Black** Completed er than "natur, the Medical E 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Harrod Thomas Harrod P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 5213 Fredcrest Road Baltimore, Maryland 21229 Robert Harrod Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If it any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/27/06 Baltimore, Maryland Arbutus Memorial Park 21. Sign sure of Juneral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutow Place Baltimore, Md 21217 23a. Part1. Enter the die shock, or heart failur e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fina disease or condition resulting in death) **Physician** st cute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or an a consequence of) Examine The law requires that the death certificate be executed nivo Due to (or as a consequence of): P.O. Box 68760, physician the burial Physician/Medical SS attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 1 □ Yes 2 □ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 🗌 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has t rector, page 2 s autopsy performe 1∐ Yes 2 - NO or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient ဠ 1 Inpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending investigation s after death. I Director: A id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I completely filled filled To the Hospital 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/21/2006

State Registrar

Indrew 31. Date filed (Month, Day, Year) DEC 2 8 2006

32. Registrar's Signature

30. Name and oldress of person who completed cause of death (Item 23a) (Type, Print)

00047804

Aberdeen Plane Aberdeen 17 D 21001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician Irusta Carla December 18 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Johns Hopkins If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 XF Maryland Director December 18, 2006 N/A Usual Residence of Decedent deeth with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21210 548 West University Parkway or items 23e by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Bi-Racial 3 ☐ Widowed 4 ☐ Divorced "naturel". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill Depertment of Health and Mental H Important: If Item 27 is marked otteny injury or other traumatic even Be Clare Muhoro Pablo M. Irusta 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 548 West University Parkway, Balto, Md 21210 Pablo M. Irusta-Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 12/22/06 Baltimore, Md 21. Signature of Funeral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, a 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Extreme Prematurity **Physician** /Medical Due to (or as a consequence of) Examiner Advanced orvical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached ,2006 9 Unknown 9 Unknown December 18 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ **6**9 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a Was an After this certificete has 1 Yes 2□ No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 No 2 EP/Outpatient 3□ DOA funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie December 18, 2006 D0052071 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe Street Baltomore, Maryland 600 North Gurewitsch Edith 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 2 8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Jor dan 2:40 PM croy 23 /Medical 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NIA of Maryland Medical Center University Beltimore 6. Sex 1 1 M M 2 □ F If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 220-82-5787 Director 44 5-28-1962 Md Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at Md N/A Baltimore Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 55 S. Fulton Avenue 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛛 No þ Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation event, the Medical 16b. Kind of Business/Industry N/A (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/ADisabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Allen Jordan 2 Edith Cox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Jordan - Sister 2938 W. Coldspring Lane Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stat permit. Pages 1
Department of the important: if ite any Injury or ot ₩ Burial 2 Cremation 3 Removal from State Mt Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1-2-2007 Lansdown, Md 21. Signature of Funeral Service Micensee 22. Name and Address of Facility March F/H West 21215 trome 4300 Wabash Avenue Shom D80N Baltimore, Md 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Stax Duodena 1 disease or condition resulting in death) 9 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending physical for use as the b 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 1□ Yes 2 or Attending Physician; 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral D LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 23, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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Carle !

SOUTH GREENE STREET

32. Registrar's Signature

BACTIMURE, M) 2(201

Tyrone Johnson		Sta 1- For State Registrar	ite of Maryland /	Certificate		Mental Hygiene	Reg. No. 200	6 4149
Physicia		Decedent's Name (First, Middle,		1	~~	Date of Month	Day Year	3 Time of Death
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		Harbor Hospital Center			Baltimore	ation of Death	140. County of Dea	
Funeral		Social Security Number	S. Sex 7 Age	(In yrs last birthday)			f Birth(MM/DD/YYYY) 9. B	
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'n		Usual Residence of Decedent 10a State 10b, County		10- 07 -				
ow any		- 4		10c. City, Town or Loc				10d. Inside City Limits 1 Yes 2 No
Aaryland 28a-f show 1 at once.	tor	10e. Street and Number		Baltin	10R Code		10g. Citizen of What Co	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	Funeral Director		Avenue		2122	25	() 5 F	
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and 2 shoul lealth and N tem 27 is m	ြ	19a Informant's Name/Relationshi	le Beard-me	other 707		Number of Rural Route + Ballim	Number, City or Town, Stat	e, Zip Code)
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Baltimore, permit. Pages I ar Department of Hee Important: If itel			3 Removal from Stat	e crematory or a		12/22/00	o Woodlaw	n, Md
Baltir permit. P Departme Importal injury or		21. Si ture of Fu ral Service L			Name and Address of F	acility M, len's l	netropolitan	
De De E	d la	/wiffing /	fullen		639 N. BR	oudway 1	halte Md.	11213
Physician /Medical		23a. Part I Enter the disease, or confailure. List only one cause of	omplications that caused the n each line.	he death. Do not enter	the mode of dying, such	n as cardiac or respiratory	arrest, shock, or heart	Approximate Interval Between Onset and
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3760 ficate b g physic s the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome		etal death 3 E	etonio pro populari	23d. Date of deliver	,
Box 6876 death certificate the attending phy	sician/	past 12 months?	4 Pregnant at ti	me of death	etal death 3 E	ctopic pregnancy	Month	Day Year
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Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director: After this certificate has been sted in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.		05.14				1 🗸 Ye	es 2 No 1 V	es 2 No
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IVISIOI or Attene after death Director:	įįį	3 ✓ Suicide 6 Could	28e Place of Inju		eet, factory, office buildin		n (Street and Number or Ru	ural Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical						ause(s) and manner as state and place, and due to the	
To To com	Med	29b. Signature and title of certifier	and manner stated	-	29c. License nun		29d Date signed (Mo	
		701:110	as AC		O.C.M.E.		December 15, 2	
2	ł	30. Name and address of person w	ho completed cause of de-	ath (Item 23a)				
σ		Zabiullah Ali, M.D. As	ssistant Medical Exa		nn Street, Baltimor	re, MD 21201		
St Regist	ate	31 Date filed (Month, Day Year)	8 2006 32. Registrar's	s Signature	Carti			
Regist	uell	m so w H	V 100	with the self	a library description			

06-09682 Rickey Jackson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ey Jackson		1- For State Registrar	or Maryland / Depa Cer	rtificate of Dea		, ,	teg. No. 20	06 414
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N. S.		2207 East Biddle Street	ve street and number)		timore	or Death	NA	all I
Funeral Director			7. Age (In yrs. Ia X M 2 F 54	Mor	nder 1 Year If Undenths Days Hours		rth(MM/DD/YYYY) 9. 1952	Birthplace (State or reign Country)
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limit
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ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 2207 E. Biddle	Street	10f. 2	Zip Code 21213		I0g. Citizen of What C	ountry?
or items 2.	Funeral	11. Marital Status 1 Never Married 2 Marrie	1 Yes 2 X No	If Yes, spe	cify Cuban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	White, etc	
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nd 2 should be all the and Mer m 27 is man aumatic even	10	19a. Informant's Name/Relationship (Celia D. Jackso		19b. Mailing Addre 2207 I	ss (Street and Num E. Biddle	nber or Rural Route Nu Street, Ba	nber, City or Town, St ltimore, M	ate, Zip Code) d. 21213
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hysician /Medical		23a. Part I. Enter the disease, or comfailure. List only one cause on e	each line.			ardiac or respiratory ar	est, shock, or heart	Approximate Interv Between Onset an
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or Ati after de Direct I in by	Certification:	3 Suicide 6 Could no	t be 28e. Place of Injury - At ho	ome, farm, street, facto	ry, office building, et	c. 28f. Location (or Town, S		Rural Route Number, Cr
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To the Ho within 24 P To the Fur completely	Medical	one) 2 Medical Examine	er:On the basis of examination ar and manner stated	nd/or investigation, in	my opinion, death oc		and place, and due to	the cause(s)
	Z	29b. Signature and title of certifier	nd	2	9c. License number O.C.M.E.		29d Date signed (A	
		30. Name and address of person who Ling Li, MD Assistant N		Penn Street, Ba	timore, MD 212	01		
S Regis	tate	31. Date filed (Month, Day, Year) DEC 2 8	32. Redistrar's Signatu	irek fierk	7			· · · · · · · · · · · · · · · · · · ·
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			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N 2 0 0 6 4 1 4 9 5
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	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City_Town, or Location of Death 4c. County of Death
		diser.	NUMOI altopital at Easter Easter Talbot
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	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
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Baltimore,	of He of He or other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
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			23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strick, or heart failure. List only one cause on each line.
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P.O.	thet the de ed by the detached	Physician/Med	1 Yes 2 No 4 Pregnant at time of death 5 Utner (specify)
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Re	The lav	Completed	24a. Was an autopsy findings available autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
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	the thin 24 of the Foundation		and manner stated.
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	6		Name and address of person who completed cause of death (Item 23a) (Type, Print)
	Sta	te	29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 23, Physician Christine Eleanore Jasinski 1:50 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Summer Ford Place Howard Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 □XF Director 129-32-2752 63 Oct. 21, 1943 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar more. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5959 Gentle Call USA 21029 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced White white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Analyst Property management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edmund Kantor Eleanore Lipczynski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5959 Gentle Call Clarksville, MD 21029 Stanley Jasinski - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Merto Crematory Baltimore, MD Dec. 26, 06 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part if Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Death Immediate Cause (Final **Physician** MALONANT ANGHOWIA disease or condition resulting in death) /Medical nsequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transi attending physician and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical the as s 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Tes 2 Tvo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Dether (Specify) LIVING ٩ 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural Injury after death. 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Event, MD. 0552 BRRY

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registra s Signature

2006

		1- For State of Maryland / D	epartment of Healt			ene . n2 0 0 6	11197
Physic		Decedent's Name (First, Middle, Last) Anngrenett Jobes			2. Date of Death Month	Day Year 23 2006	3. Time of Death 2:42 A M
/Med Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locati		12	4c. County of Dea	th
Funeral Director		Corsica Hills Nursing Home 5. Social Security Number 213-22-6145 6. Sex 1 M 2 TF 7. Age (In yrs. last birt.) 106 v	hday) If Under 1 Year if Un	rs Min.	8. Date of Birth (Month, Day, Yo 12/12/1900		thplace (State or Foreign buntry) MD
Maryland 1-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD	or Location Baltimore	e			10d. Inside City Limits 1 X Yes 2 ☐ No
th with the 23a or 28	ai Director	10e. Street and Number 4600 Springdale Avenue	10f. Zip Code	21207	10g.	Citizen of What Co USA	ountry?
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and 2 sho lealth and m 27 ls m		Constance L. Brent / Niece	Mailing Address (Street and Nu. 4600 Springdale Addressition (Name of	venu; Ba	ltimore, M	aryland 21	207
t. Pages 1 tment of h rant: if Ite		1X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Union W	esley Cemetery	12/29/2	.006 CI	c. Location - City or hester, Mar	yland
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To t To t	Σ	29b. Signature and title of certifier	29c. License numb	036	29d.	Date signed (Month	h. Day, Year)
·B		30. Name and address of person who completed cause of death (Item 23a)	Sype Print) on wh Dri	ue C	Lucher,	MO 21	619
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Hegistrar's Signature 32. Hegistrar's Signature	docate)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. _ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 25 PM esha nnson 2006 paniar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Maryland Medical Center altimore 9. Birthplace (State or Foreign ^{Yea}r) 2006 **Funeral** 215-77-0187 Hours Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "naturai", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Glen Burnie 100 Street and Number 1775 Monaghan Rd. 10f. Zip Code 21060 10g. Citizen of What Country? USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 ☐ Yes 2 No
If Yes, Give Black, White, etc. and 2 should be filed within 72 hours after of teath and Mental Hygiene.

m 27 is marked other than "natural", or iten ther traumatic event, the Medical Examiner ther traumatic event, the Medical Examiner. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) N/A College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Terry Johnson Shawntia Campbell ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health Shawntia Campbell, mother 7775 Monaghan Rd. Glen Burnie, MD. or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of important: If any Injury or 4 □ Donation 5 □ Other (Specify) West Arundel Crematory 12-26-06 Odenton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 23a. Fant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** ulmonaei disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Depsis

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) as been signed by the 2 should be detached 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
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within 24 hours a To the Funeral L

Registrar

31. Date filed (Month, Day, Year)

DEC 2 8 2006

DHMH 17 Rev 1/2001

22 S. Greene

Street, M5W68, Baltimore ms 2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician /Medical **Examiner**

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, th- Medical Examiner must be notified at

signed by the attending physician and I be detached for use as the burial-tran

Certification:

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The law requires that the death certificate be executed has Hospital or Attending Physician: '44 hours after death. Funeral Director: After this certifica e Funeral

Division or Vital Records, P.O. Box 68760,

To the within 2

State Registrar

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of pertified

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

street #200 Reistertown Mandana hbazi

31. Date filed (Month, Day, Year)

32. Registrar's Signature

				Ctata of Mandana	4 / Damanton	- 4 - 4 4	Montal Liveis		
			1 _ For State	State of Maryland			i Mentai Hygie	ene 2006	1.1500
			Registrar		Centitica	ite of Death		. No U U U	71000
	Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
w/a.	/Medic		6-e019e	William		JE NZEN	DECEMB		16.01 PM
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an	ntal ntal od o	Be.	Oscar Charles Jenser	ı Sr.			n Anna Hughes	ison semano,	
2	houk d Me mark mark	၉	19a. Informant's Name/Relationship (Ty)		19b Mailing Addre	ss (Street and Number or		City or Town State Zin	Code)
Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Itam 27 Is marked othar than "natural; or Itema 23a or 28a-1 ahow any fujury or othar traumatic avant, Itia Mudical Examinar must be notified at anone.		Allan P. Jensen - Broth	ner			Monkton, MD 21		, 0000,
ē,	1 an Heal tam 2	1 6	20a. Method of Disposition	20b. Pla	are of Disposition (A	lame of	Date 20	c. Location - City or To	own, State
Baltimore, Maryland 21215-0036	ages ant of it: If I		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State Mead	lowridge Mem	orial Park 12/	'29/06 E	lkridge, Mary	/land
	ortan Injur		21. Signature % Funeral Service License	1		and Address of Facility	5305 Harf	ord Road	
B	Depermine Deperm	Ι,	Charles It	ine of	Leonar	d J. Ruck, Inc.		, MD 21214	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or		. Do not enter the m	ode of dying, such as card			Approximate
	Dhysisian		tmmediate Cause (Final						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	ence off:	aionyope	: My		16 YECUS
	Examiner		1				9		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (Sr as a consequ	onea of):				
	but d ansit	Examiner	Cause (Disease or injury that initiated events						
o o	le be executed ysicien and e burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):				
760,	ite be executed lysicien and he burial-transit	ical		J					
68	that the death certifical ed by the attending phi detached for use as th	by Physician/Medi	tF FEMALÉ:						
Вох	th ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of		pregnancy		23d. Date of delive	*
Э. Н	e dea	slci	1 Yes 2 Thu	4 Pregnant at time of dea 9 Unknown	ath 5 Other	(specify)		Month	Day Year
о. О.	d by t	Phy		Acids at a second by the second	Mine in the conduct in	in Death	On Didash		
Ś	signed d be de		Part II. Other significant conditions con	ntributing to death but not resul	iting in the underlying	cause given in Part I.	23e. Did toba	cco use contribute to to	ne cause of death?
or o	w require been si should I	ted					- Tes	21/21/00 3 1-100	Jabiy 4 Donknown
	3 Q 5	- %					24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
ec	9 la 9 la 9 2	2					performe		
l Rec	: The lav	Comp					1 ☐ Yes 2 ☐	Ango I 🗆 Tes	2 □ No
/ital Rec	ician: The la entificate he: ector, page 2	Be Completed	25. Was case referred to medical examiner?	Jacquital:			Death Check only one	Arago I 🗆 Tes	2□ No
of Vital Rec	Physician: The la this certificate he: al director, page 2	To Be	examiner? 1 □ Yes 2 XNo	fospital: 1 Inpatient 2 🗆 E		DOA Other: 4 🗆 Nursing	Death <i>Check only one</i> g Home 5 Residence	ce 6	
on of Vital Rec	iling Physician: The law requires that the Aler this certificate hes been signed by th uneral director, page 2 should be detache	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 Minpatient 2 E	28b. Time of Injury	Other: 4 Nursing 28c. Injury at Work?	Death Check only one	ce 6	
ision of Vital Rec	ttanding Physician: The la death. tor: After this certificate he: the funeral director, page 2	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	ODA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No	g Home 5 Residence 28d. Describe how	ce 6 □ Other (Specifinitury occurred	jy)
Division of Vital Records,	or Attanding Physician: The la effer death. Diractor: After this certificate he: I'n by the funeral director, page 2	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Minpatient 2 L E	28b. Time of Injury M	ODA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No	g Home 5 Residence 28d. Describe how	ce 6 Other (Specification of the following occurred	jy)
Division of Vital Rec	iptital or Attanding Physician: The la nous elter death. Interest Director: After this certificate he: filled in by the funeral director, page 2	Certification; To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Ptace of Injury - At hor building, etc. (Specify)	28b. Time of Injury M me, farm, street, fact	OOA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No ory, office	Death Check only one g Home 5 Residence 28d. Describe how 28f. Location (Stre. City or Town.	ce 6 Other (Special injury occurred set and Number or Rura State)	iy) al Route Number,
Division of Vital Rec	Hospital or Attanding 4 hours effer death. Funeral Diractor: After ely filled in by the fune	Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 2 Homicide Certifying Physics	28a. Date of Injury (Month, Day Year) 28e. Ptace of Injury - At hor	28b. Time of Injury M me, farm, street, fact	DOA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No ory, office	Death Check only one g Home 5 Resident 28d. Describe how 28f. Location (Stree City or Town.	te 6 Other (Special injury occurred let and Number or Rura State)	if Route Number,
Division of Vital Rec	Hospital or Attanding 4 hours effer death. Funeral Diractor: After ely filled in by the fune	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier Check only 2 Medical Examin	28a. Date of Injury (Month, Day Year) 28a. Ptace of Injury At hor building, etc. (Specify) sician: To the best of my knowner: On the basis of examination	28b. Time of Injury M me, farm, street, fact vledge, death occurre on and/or investigati	DOA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No ory, office	Death Check only one g Home 5	te 6 Other (Special injury occurred let and Number or Rura State)	tated. o the cause(s)
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